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# Index to Volume XLIII

## Editorials


Page

Accommodation for Returned Soldiers 56
American Doctors in England ..... 92
American Hospitals in England..... 306

Base Hospital, Toronto, The..... 359
Blinded Soldier, The. ..... 360
British Doctor in Parliament, A..... 180
Brown, Capt. Percy B. ..... 133

Canada in the War..... 361
Canadian Medical Week in Hamilton.. 93
Canadian Medical Protective Association ..... 130
Canadian Public Health Association.. .95
Canadian Medical Association ..... 253
Canadian New Year's Honors ..... 69
Care of Invalid Soldiers ..... 18
Care of Returned Soldiers, The..... 128
Care of Young Babies, The ..... 153
Children and Tuberculosis ..... 184
C.A.M.C. News ..... 362
Correspondence .....99, 372

Doctor at the Front, The ..... 19
Doctors and the Law ..... 229

Editorial Notes.....21, 131, 184, 195, 279
England and the War ..... 185
Expense and Inconvenience of Quarantine, The ..... 181
Epidemic Influenza ..... 333

Federal Bureau of Health ..... 254
Food and the War ..... 250
Fifth Year Results Faculty of Medicine 256
Food Supply, The ..... 61
Food Poisoning ..... 20

General Election in Great Britain, The 306
German Language, The ..... 227

Halifax, Disaster, The ..... 50, 157
Hamilton Medical Week, The ..... 154
Health Matters in Ontario ..... 19
Health of Prince Albert ..... 22
Health in Ontario ..... 256
Hendry, Col. W. B. ..... 132
Home for the Aged ..... 257
Hospitals in France ..... 271
Hospital Ships ..... 256
Hun and the Wounded Soldier, The... 159

Influenza Epidemic, The Recent..... 355
Institute of Public Health, London... 279

Page

King George and Queen Mary ..... 334

Lantern Pictures of the Soldiers' Return ..... 62
Llandovery Castle Outrage, The ..... 335

Medical Inspection of Schools in Toronto ..... 129
Medical Fees ..... 181
Medical Students in Military Service. 253
Memorial Hospital for Elgin County... 361
Memorial for Dr. Young ..... 257
McKeown, Lieut.-Col. Walter ..... 257
Medical Week in Hamilton, The..... 238

News Items....22, 63, 96, 132, 161, 188 256, 280, 308, 338
Ontario Medical Council .....21, 305

Personals....23, 64, 97, 134, 165, 191 260, 282, 313, 364
President of the Ontario Medical Association ..... 278
Prevention of Typhoid in the Canadian Army ..... 57
President's Address, The..... 230
Pyne, Honorable Doctor ..... 225
Pre-Operative Purgation ..... 337

Ramsay Gift, The ..... 252
Reports of the Commission..... 86
R. A. M. C. ..... 226
Red Cross Donation to Canada ..... 336

Secours Nationale, Toronto Branch... 132
Spread of Scarlet Fever, The ..... 156
Students of Laval University ..... 59
Substitutes for Butter ..... 22

Treatment of the Blind, The ..... 276
Toronto General Hospital ..... 277
Toronto Medical Representative in the Dominion House ..... 21

University of Toronto Recent Graduates ..... 184

Versatility of the Hun, The ..... 182

War Strain on Generals, The ..... 158

## Obituaries


Page

Anderson, John W., M.D. ..... 234

Baker, Hiram Richard, M.D. ..... 345
Baptie, Geo., M.D. ..... 138
Beal, Norman H., M.D. ..... 369
Blaylock, Lieut.-Col. Harry ..... 167
Brewster, R. S., M.B. ..... 368
Boyle, James F., M.D. ..... 369
Brown, W. E., M.D., C.A.M.C. ..... 284
Brown, Walter Norman, M.D. ..... 315
Brown, James Ewart, M.D., L.R.C.P., Edin. ..... 346

Carleton, W.H., M.B. ..... 138
Cameron, Hugh, M.D. ..... 262
Clare, Lieut. A. Murray, M.D. ..... 285
Conroy, Peter, M.D. ..... 138
Cotton, J. Milton, M.D., M.R., C.S., Eng. 285
Crothers, Thos. Davidson, M.D., Hartford, Conn. ..... 70
Cullen, Emma Jones ..... 316
Chapelle, Walter F., M.D., F.R.C.S., Eng. 345

Elliston, Guy, M.R.C.S., Eng. ..... 263

Faulds, R. W., M.D. ..... 366
Francy, C. H., M.D. ..... 346
Fitzsimmons, Wm. T. ..... 25
Fotheringham, Susan L., M.B. ..... 365
Freel, Sylvester Lloyd, M.D. ..... 347

Gear, Sub-Lieut. J. D. ..... 371
Gilmour, John T., M.D. ..... 285-287
Girdwood, G. P., M.D. ..... 25
Groves, Osler Monk, M.D., L.R.C.P. & S. 347
Guilfoyle, T. R., M.D. ..... 366
Guiteras, Raymond ..... 26

Haight, Mortimer H., M.D. ..... 139
Hale, W., M.D., D.S.O. ..... 262
Hamilton, W. H., M.D. ..... 138
Hanna, Adelbert E., M.D. ..... 140
Hastings, Andrew Orr, M.D. ..... 370
Henderson, E. K., M.B. ..... 368
Hutchinson, T. V., M.D. ..... 167
Hutt, W. G., M.B. ..... 284

Irwin, Brig.-Gen. Bernard J. W., M.D. ... 24

Jamieson, Theodore C., M.D., Lon., M.R.C.S.E. ..... 24
Janeway, Theodore C., M.D. ..... 67
Jessop, Elisha, M.D., M.P.P. ..... 367
Johnston, J. A., M.D. ..... 365
Jones, C. M., M.R.S.C. ..... 194
Jones, Richard, M.D. ..... 138

Kelly, Charles J., M.D. ..... 67, 139

Page

Lachapelle, E. P., M.D., LL.D. ..... 315
Leary, E. J., M.B., ..... 284
Lowe, James Henry, M.D. ..... 263
Little, Neville H., M.D. ..... 366
Little, William Thomas, M.D. ..... 370
Luton, William Franklyn, M.D. ..... 368

McCabe, John C., M.D. ..... 365
McClure, Robert, M.D. ..... 365
Macrae, Lieut.-Colonel John, M.D., C.A.M.C. ..... 101, 167
McCoughlin, Hugh, M.D. ..... 67
McKibbin, Louis G., M.D. ..... 139
McKinnon, Kenneth, M.B. ..... 371
McLerty, Colin, M.D. ..... 263
Mitchell, Dr. ..... 262
Mungan, Philip Joseph, M.D. ..... 68
Munro, Robert Walter, M.D. ..... 365

Nagle, F. W., M.D. ..... 68
Newton, John, M.D. ..... 139
Nixon, Alfred W., M.D., M.P.P. ..... 346

Ogden, Austin, M.D. ..... 100
Osler, Lieut. ..... 69

Pollard, Stephen Ballard, M.D. ..... 68
Palling, Capt. J. F., M.D. ..... 100
Parker, Arthur Allan, M.B. ..... 370
Powell, Maj. Allan D., D.S.O. ..... 194

Richards, Nicholas D., M.D. ..... 194
Ritz, John H., B.A., M.D. ..... 100
Robertson, Patrick, M.D. ..... 194
Ross, Andrew, M.B. ..... 366
Rutherford, James B., M.D. ..... 369

Sargent, Willis A., M.D. ..... 367
Shannon, P. R., M.B. ..... 368
Sivewright, J. P., M.B. ..... 263
Slack, G. F., M.D. ..... 284
Smith, Robt. W., M.D. ..... 67
Stapleton, James L., M.D. ..... 367
Stinson, Albert W., M.D. ..... 367
Stirrett, Ernest Zavitz, M.B., R.C.M. .. 68
Swenerton, W. C., M.D. ..... 366
Switzer, Frank L., M.D. ..... 138

Tait, Lieut. Wilfrid, R.A.F. ..... 263
Thomas, Geo. Napier, M.D. ..... 67
Todd, Major J. Harvey, M.B. ..... 345
Travers, Boyle, M.D. ..... 263

Walker, Henry C. R., M.D. ..... 262
Walker, Henry, M.D. ..... 315

Young, W. D., M.D. ..... 69

## Book Reviews


Page

Anatomy, A Manual of. By Henry Erdmann Radasch, M.Sc., M.D. ..... 27

Canadian Medical Directory. By N. W. Moore, M.D. ..... 196
Clinical Medicine, A Treatise on. By Wm. Hanna Thompson, M.D., LL.D. 290
Clinical Diagnosis. By James Campbell Todd, M.D. ..... 348

Diabetic Manual for the Mutual Use of Doctor and Patient. By Elliott P. Joslin, M.D. ..... 290
Differential Diagnosis. By Richard C. Cabot, M.D. ..... 291
Diseases of the Skin, Their Pathology and Treatment. By Milton B. Hartzell, A.M., M.D., LL.D. ..... xiv

Essentials of Prescription Writing. By Carey Eggleston, M.D. ..... 169

Food for the Sick. By Solomon Strouse, M.D. ..... 28
Fundus Oculi of Birds, Especially as Viewed by the Ophthalmoscope. By Carey Albert Wood ..... 71

Gynæcology. By Wm. P. Graves, M.D. 349

History of Medicine. By Fielding H. Garrison, A.B., M.D. ..... 27
Human Intestinal Protozoa in the Near East. By Temp. Lieut.-Col. C. M. Wenyon, B.Sc., M.B., B.S. ..... 291

Infant Feeding, Clinical Lectures on. By Lewis W. Hill, M.D. ..... 195
International Clinics, Vol. 1. By H. R. M. Landis ..... 170
International Clinics, Vol. 1v. By H. R. M. Landis ..... 196

Page

Laboratory Manual of Qualitative Chemical Analysis, A. By A. R. Bliss, Jr., M.D., Ph.G. ..... 349

Manual of Otology. By Gorham Bacon, A.B., M.D., F.A.C.S. ..... 348
Military Orthopædic Surgery. By Orthopædic Council ..... 350
Manual of Clinical Diagnosis. By Charles E. Simon, B.A., M.D. ..... 168
Medical Service at the Front. By Lieut-Col. John McCombe, C.A.M.C., and Capt. A. F. Menzies, M.C., C.A.M.C. ..... 318
Medical War Manuals, No. 3, Military Ophthalmic Surgery. By Allan Greenwood, M.D., Major M.R.C., U.S.A. ..... 317

Notes of Army Medical Officers. By Lieut.-Col. T. H. Goodwin, R.A.M.C. 28
Nutrition, The Elements of the Science of. By Graham Lusk, Ph.D., Sc.D., F.R.S. (Edin.) ..... 292

Obstetrics, A Text Book of. By Barton Cooke Hirst, M.D ..... 289
Otology, A Manual of. By Gorham Bacon, A.B., M.D., F.A.C.S. ..... 348

Practice of Medicine, A Text Book of The. By James M. Anders, M.D., Ph.D., LL.D. ..... 186
Pocket Formulary, A. By E. Quinn Thornton, M.D. ..... 292
Progressive Medicine. By Hobart Amory Hare, M.D. ..... 71, 169, 289

Spleen and Anæmia, The. By Richard Mills Pearce, M.D., Sc.D. ..... 169


## Articles


Page

Abnormal Blood Pressure, The Management of ..... 11
Academy of Medicine ..... 29
Accommodation for Returned Soldiers. 56
Acute Lobar Pneumonia ..... 171
Anorectal Varices in Pregnancy, Treatment of ..... 114
Apparently Drowned Persons ..... 216
At What Age Should Infants be Vaccinated ..... 275
Air Training Casualties ..... 339

Bronco-Pneumonia in Children, Treatment of ..... 35

Canadian Medical Week in Hamilton, Some Reflections on..... 219
Cancer Problem, The ..... 329

Page

Camphor in Cardiovascular Disease... 37
Carcinoma of the Cervix by Radium Pallative, Treatment of Inoperable 37
Convalescence, The Treatment to be Applied During ..... 112
Cruel Injustice, A ..... 338
Cystoscope, An Essential in Genito-Urinary Surgery ..... 145
Cardiac Hypertrophy in Aviators ..... 321

Doctors and the Influenza ..... 339
Duct Cancer of the Breast, The Diagnosis of ..... 172
Dyspnœa in Bright's Disease..... 141

Earache and Its Management ..... 173
Erythema Nodosum ..... 264
Eusol Injections in Children ..... 38

| | Page |
|---|---|
| Fatigue and Alcohol | 34 |
| Gas Bacillus Infections, The Conquest of | 109 |
| Goitre Exophthalmic | 31 |
| Grip of Germany on Many Industries | 373 |
| Hæmoptysis, Treatment of | 103 |
| Hunger in Infants | — |
| Infantile Paralysis, Some Clinical Form of | 77 |
| Infectious Diseases, The Use of Hormone Equations in Acute | 197 |
| Medical Health Officers Can Become a Co-operative Social Force in Rural Districts | 121 |
| Medicine and Democracy | 205 |
| Mendelism | 295 |
| Management of a Child Welfare Week in Small Cities and Towns | 302 |
| News Items | 22-63 |
| One Non-essential Industry | 376 |
| Obstetric Forceps Versus Drugs | 82 |
| Obstetric Fads and Heresies | 201 |
| Ontario Medical Association | 266 |
| Ontario Medical Council | 293 |
| Plea and a Plan, A | 272 |
| Peptic Ulcer, Treatment of | 200 |
| Prevention of Venereal Disease | xxiv |
| Points on General Anæsthetic for the Surgeon | 325 |
| Poliomyelitis | 39 |
| Pre-Operative Purgation | 337 |
| Peel County Medical Association | 338 |
| Potassium Permanganate and Colloidal Manganese in Gonorrheal Sepsis | 324 |
| Recent Advances in the Operative Treatment of Certain Intracranial Conditions and Especially of Brain Injuries | 1 |
| Reports of Societies | 29 |
| Radium Therapy in Hyperthyroidism With Observations on the Endocrinous System | 236 |
| Radium Therapy in Uterine Cancer | 203 |
| Radium in Tuberculosis of the Skin | 42 |
| Radium in Non-Malignant Uterine Hæmorrhage, Use of | 76 |
| Sarcoma of the Prostrate in Boy Aged Four and a Half Years | 38 |
| Simulation of Disease | 33 |
| St. Andrew's College | 215 |
| Surgery in 1918 | — |
| Syphilis, Treatment of | 175 |
| Trench Nephritis | 73 |
| Use of the Longitudinal Simus for Diagnosis and Treatment | 319 |
| Veronal Poisoning, Prevention of | 75 |
| Vocational Training | 115 |
| Vaccine Treatment, The Disappointments of | 351 |

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## Original Communications

### RECENT ADVANCES IN THE OPERATIVE TREATMENT OF CERTAIN INTRACRANIAL CONDITIONS, AND ESPECIALLY OF BRAIN INJURIES*


By William Sharpe, M.D.

Professor of Neurological Surgery, New York Polyclinic Hospital and Medical School, New York City.


The field of neurological surgery has so developed within the last decade that I wish this evening merely to emphasize some points in the diagnosis and treatment of certain lesions of the brain, spinal cord and the peripheral nerves. This advance in neurological surgery has been due to three main factors:—earlier and more accurate diagnosis and localization, an improved operative technique, and, most important, better team-work—not merely between the operator and his assistants, which is most necessary for successful cranial operations, but of still greater importance that essential team-work between the surgeon and the neurologist at his side; formerly the neurologist knew little, if any, surgery, and the operator knew little, if any, neurology; the result was frequently disastrous to the patient. The surgeon should have a practical knowledge of the principles of neurology—the more neurology the surgeon knows so much the better will be his operative results; much permanent damage can very easily occur if general neurological principles are ignored.

If neurological surgery consisted chiefly in the removal of brain tumors it would be indeed a most discouraging field of endeavor. As you know, almost 80 per cent. of tumors of the brain are malignant, and even though a surgically successful

* Read at the Annual Meeting of the Ontario Medical Association, Toronto, Canada, on May 31, 1917.

removal of the tumor is possible, yet the end results are the same—the pitiful condition of the patient is merely prolonged; the severe headaches, however, and the impairment of vision are thus temporarily relieved and even prevented by an early operative removal of the tumor. No patient should be allowed to become impaired visually from the increased intracranial pressure due to the growth of an intracranial tumor merely because the tumor cannot be located. These patients all should have an early decompression to relieve this increased intracranial pressure, so that the vision will be spared, and then, if the tumor does locate itself later, a successful removal of the tumor may be possible, and yet the patient is not blind; I wish to emphasize this point, as it is most discouraging to operate upon these neglected cases of brain tumor who have become blind.

Tumors of the spinal cord, on the contrary, are much more favorable in that there is less liability of their being malignant, they can be more accurately located and are much more accessible surgically. The operation of laminectomy has become much less formidable within the past few years so that an exploratory laminectomy of a suspected spinal cord tumor should always be advocated early in order to anticipate any permanent damage of a compression transverse myelitis. The frequency of benign dural tumors of the spinal cord is most hopeful.

The condition of brain abscess has always been a most grave one. It usually results from an otitis media with its subsequent involvement of the mastoid; the usual site is the contiguous temporo-sphenoidal lobe, and less frequently the adjacent cerebellar lobe. As lesions of the cerebellum can be much more accurately diagnosed than those of the temporo-sphenoidal lobe; therefore, if we can rule out a cerebellar abscess, then the site must be in the temporo-sphenoidal lobe—a comparatively silent area of the brain, especially the right lobe in right-handed patients. Formerly the otologists, in cases of suspected abscess of the temporo-sphenoidal lobe, would puncture the dura in search of the abscess through the "dirty" infected field of the mastoid; as all operations for brain abscess are really exploratory procedures, it is distinctly unsurgical to open the clean subdural spaces and to puncture the cerebral-cortex itself through an infected area; if the abscess is not located (and this frequently happens) then the patient runs the big risk of a resulting meningitis, and thus the usual occur-

rence—the exitus of the patient. Besides, the dura should not be punctured blindly with a knife or puncture needle unless the dura has been opened so that it can be clearly ascertained whether an underlying cortical vessel is present or not; many disasters from the resulting hæmorrhage have frequently occurred from such procedures. It is much more rational surgically, and a much better exposure is obtained to locate the abscess if the operative incision is made through the "clean" sub-temporal area, just as in a sub-temporal decompression—the vertical incision naturally being used; if the abscess is found, then it can be satisfactorily drained through the lower angle of the incision at the base of the skull; and if the abscess is not found then at least a decompression has been performed so that the intracranial pressure is relieved until the abscess may locate itself clinically, and the great danger of a meningitis and infective meningo-encephalitis has been avoided. In my series of brain abscess cases there are a number of them which I am sure I should have missed surgically if I had not used the better exposure of the sub-temporal route.*

The condition of cerebral spastic paralysis occurring in children is a most interesting study. In 1843, Mr. Little, of London, in his first monograph upon this subject, stated that these cases were due to a lack of development of the cerebral tissues, and also to an earlier meningitis; he did mention, however, that this condition apparently followed in some cases of difficult and prolonged labor, with or without the use of instruments, and were undoubtedly, in his opinion, due to an intracranial hæmorrhage; it is most interesting to note that in his second monograph upon this subject nineteen years later, in 1862, he states that, in his opinion, three-fourths of these cases of cerebral spastic paralysis in children are due to hæmorrhage. These observations have been confirmed recently by more modern methods of diagnosis; it was formerly believed hæmorrhage in these cases caused a primary destruction of brain tissues; therefore, no regeneration was possible, and thus any operative procedure would be of no value in treating the condition. Within the last five years I have had the opportunity of examining and treating personally almost 1,400 children having the condition of spastic paralysis.† By the more accurate methods of differentiating the ones due to hæmorrhage from those hopeless cases due to a lack of development and to

* "The Laryngoscope," St. Louis, March, 1914.
† "New York State Journal of Medicine," October, 1916.

a former meningo-encephalitis, for which nothing really can be done, it is now possible to diagnose the ones due to hæmorrhage from these two conditions by means of careful ophthalmoscopic examinations of the fundi of the eyes, and by a measurement of the pressure of the cerebro-spinal fluid at lumbar puncture by means of a spinal mercurial manometer; if the ophthalmoscope reveals the signs of a definite increase of the intracranial pressure, and these observations are confirmed by the spinal mercurial manometer (the normal pressure of the cerebro-spinal fluid being 5 to 9 mm.), then we have an increased intracranial pressure, and if this pressure is relieved permanently by a sub-temporal decompression and its modifications according to the condition of the underlying cortex as ascertained at operation, then a definite improvement results in these cases, both physically and mentally. In this series of almost 1,400 cases there was an increased intracranial pressure in about 20 per cent. of them, that is, in about one out of every five cases examined, and these are the ones, and only the ones, that can be benefited by any operative procedure; I have now operated upon 279 of these children, and the results have been very encouraging; naturally, the younger the child, the better the prognosis—the first few days of life being the ideal time for the operation, although most of the children have been between four and six years of age; the oldest patient, however, was twenty-one years of age, and a slight improvement resulted. Naturally, a sufficient period of time has not yet elapsed for us to ascertain the ultimate condition of these patients following operation, but their improvement has been so uniform and continuous, and the pathology of the condition being a hæmorrhage *upon* the cerebral cortex, and not in the cortex itself (in only 16 cases was the hæmorrhage in the cortex or beneath the cortex), so that both the physical and mental impairments are merely the secondary results of the increased intracranial pressure due to this supracortical hæmorrhage. I might say in this condition that a permission for autopsy is obtained in all cases of neurological surgery (both private and ward patients)—no operation being performed unless this permission is given in writing—so that if a death should occur, then we shall ascertain the cause of death and also the accuracy of the diagnosis and the treatment for the benefit of future patients.

The condition of hydrocephalus has been a very interesting one; in that it has now been ascertained that the type of internal hydrocephalus is comparatively infrequent, and that the type

of external hydrocephalus is the usual condition in these cases. They both result from an earlier meningitis (if we exclude those cases of internal hydrocephalus due to tumor formation at the base), and the condition is, therefore, a diffuse one; if the ventricles are blocked by adhesions or exudate in the aqueduct of Sylvius or at the foramina of Majondie and Luschka, then an internal hydrocephalus occurs, but if no such blockage is present, yet we shall have produced an external hydrocephalus because the cerebro-spinal fluid cannot escape from the cerebro-spinal canal through the blocked stomata of exit in the cortical veins, sinuses and possibly lymphatics. The methods used in the past and occasionally now advocated of connecting the ventricles with the subdural spaces by means of tubes are, therefore, of little or no value in the treatment of this condition: even though the lumen of the tube should remain patent (and it rarely does), and even if the condition is one of internal hydrocephalus (which is much more rare than that of external hydrocephalus), yet such an operative procedure will merely be changing the condition of internal hydrocephalus to one of external hydrocephalus, and therefore, little or no improvement can be expected. The method recently used for draining the ventricles in cases of internal hydrocephalus, and of draining the subarachnoid and subdural spaces in cases of external hydrocephalus by means of linen strands is a much more rational procedure surgically than any of the methods used in the past, and its results have been very satisfactory; on the last report of 41 cases the mortality had been only thirteen patients.*

The condition of brachial plexus injury causing the so-called brachial birth palsy is the result of trauma to the plexus, due to an over-stretching of its nerves by a forceful separation of the head from the shoulder at birth. Undoubtedly, if the plexus has not been completely severed, then many patients recover from the temporary paralysis of the arm, but in those children where the over-stretching has been so severe, and even to a point of a loss of continuity of the nerve fibres, then a permanent paralysis of more or less degree will result unless the scar tissue resulting from the hæmorrhage in and about the plexus is removed and the ends of the torn nerves are anastomosed by an operation. If the arm is completely paralyzed at birth, so that not even the upper arm or the fingers can be moved, then the ideal time for the operation is at one month of age (no anæsthesia being necessary); if, however, the fingers

*"American Journal of the Medical Sciences," April, 1917.

of the upper arm can be moved slightly at birth, then we should wait until three months of age, and if no marked improvement has occurred within this time, then the operation should be performed. In these children I usually have the mother bring the child to the hospital in the morning, operate upon it, and then have the child taken home in the afternoon. The operation is not a difficult one technically, and there has been no mortality in a series of 104 cases.* These patients should not be allowed to reach the age of six years and even older without an attempt being made to improve their condition by an operation; the best results have been obtained in children under one year of age.

In fractures of the spinal column I feel that unless we can prove absolutely that there is a complete severance of the spinal cord or that the spinal cord has been irreparably contused, that we should give the patient the benefit of an exploratory laminectomy within a short time after the accident in order to remove any bony compression, hæmorrhage, or œdema of the spinal cord, and thus increase the patient's chances of a greater ultimate recovery of function. So frequently in patients whom we consider to have suffered a complete severance of the spinal cord, with complete loss of sensation and motion beneath the site of the injury, that after three months and even longer they begin to recover their sensation and also motion of the extremities formerly completely impaired; these patients are the ones upon whom an early laminectomy should have been performed, and thus the ultimate improvement would have been much greater than can be obtained at this late date. The operation of laminectomy is no longer the formidable operation of the past, and its use should be much more frequently advocated than at present; these patients are most pitiful ones —the end result, unless something can be done for them, being but a miserable existence of a few years.

The diagnosis and the treatment of brain injuries has advanced most rapidly within the last few years. The clinical symptoms and signs are so varied and frequently so confusing in these patients that it is a most fascinating field; apparently in many cases the more extensive the fracture of the skull the less seriously is the brain injured, and, on the contrary, the most dangerous of brain injuries are frequently not even associated with a fracture of the skull. The following case is rather interesting from several points of view:—

*"Journal of the American Medical Association," March 18, 1915.

On the afternoon of April the 10th, 1917, a little girl of nine years of age was returning home from school with her governess; while crossing a street six blocks from her home, she stumbled, bumping the left side of her head against the pavement; she jumped up without the assistance of the companion, and although the tears came to her eyes, yet she did not cry; she continued to walk to her home, ate her supper two hours later, and then went to bed at nine o'clock. The bump was such a trivial one that the governess did not think of mentioning it to the child's mother. At four o'clock the next morning (twelve hours after the fall), the child became restless and then vomited, but did not complain of its head at that time; four hours later, just before breakfast, it again vomited, and now the child complained of a "beating" headache, especially over the left side of the head. Doctor W. B. Hoag examined the child two hours later, to find only a slight tenderness over the left posterior parietal area (the site of the bump) and exaggeration of the deep reflexes—the right being possibly greater than the left; the pulse rate was 90; there was no ecchymosis nor bleeding from the ear. At a consultation three hours later the same signs were observed and a lessened activity of the right abdominal skin reflexes; the ophthalmoscopic examination of the fundi was negative; the child complained of a general headache and some dizziness upon raising the head; she was active mentally, so much so that she cried bitterly when we suggested her removal to a hospital for a four days' observation. She was admitted to the Polyclinic Hospital at four o'clock in the afternoon (just twenty-four hours after the injury); her pulse rate at this time was 82. A Rœntgen-ray picture was now taken, revealing an irregular line of fracture extending from the occipital protuberance forwards to the left squamous bone, but not down to the base of the skull. The measurement of the pressure of the cerebro-spinal fluid at lumbar puncture, by means of a spinal mercurial manometer, registered 16 mm. (normal, 5-9 mm); the fluid was clear. During the night the pulse gradually descended to 76 at midnight, 66 at four o'clock in the morning, and at ten o'clock the pulse rate was 58; the child had become alternately restless and drowsy—would awaken with a cry, and even scream from the intensity of the headache, and then quickly lapse into a mildly stuporous condition from which she could easily be aroused; there was now a definite inequality of the exaggeration of the deep reflexes—the right being markedly increased over the left to the degree

of both a right patellar and right ankle clonus, but no Babinski reflex could be elicited; the right abdominal reflexes were now found to be entirely abolished; the right hand grasp was possibly weaker than the left, but there was no apparent weakness of the right side of the face or of the right leg; an impaired sensation could not be elicited. An ophthalmoscopic examination at this time revealed a marked dilatation of the retinal veins and an œdematous blurring of the nasal halves and temporal margins of the optic disks—possibly greater in the left than in the right eye; there was, however, no measurable papillœdema. Speech was not impaired, nor was there present any astereognosis. No reduction of the visual fields could be ascertained, and an homonymous hæmianopsia was not present. In order to relieve the increased intracranial pressure, whether due to cerebral œdema or to hæmorrhage, a rather posterior left sub-temporal decompression was performed forty-four hours after the bump; a small line of fracture extended obliquely downwards through the squamous bone, but did not reach its base—therefore, no ecchymosis about the ear nor bleeding from the external auditory canal; upon rongeuring away the squamous bone lying beneath the temporal muscle an extradural currant-jelly clot of the thickness of 1½ inches welled up through the bony opening; as much as four ounces of clotted hæmorrhage were removed with a spoon-spatula, allowing the underlying compressed dura and brain to rise; the cavity extended upwards to the longitudinal sinus and backwards to the tentorium; a small amount of cerebral tissue was found in the upper portion of the clot, so that the dura had undoubtedly been torn in that area; the posterior branch of the middle meningeal artery had also been torn—the usual cause of this type of hæmorrhage. As the dura itself was now no longer under tension and the underlying cerebral convolutions could be clearly observed, it was thought to be better surgical judgment not to open the dura in this case. The temporal muscle and fascia were now sutured and then the scalp—two rubber tissue drains having been inserted extradurally. The convalescence was uneventful; pulse rate became 76 upon the first day post-operative, and the other signs noted above quickly faded away, so that the child made an excellent recovery.

The main points of this case have been described in detail in order to illustrate the apparent triviality of the initial symptoms and signs of many brain injuries with or without a fracture of the skull. Similar cases of an acute intracranial lesion

occur not so infrequently but that we should always be most careful in our examinations of patients having a history of a recent head injury of even the most trivial character, and especially is this true of children who withstand the effects of brain injuries much better than adults. There are several tests that should always be employed and repeatedly performed, if necessary, upon these patients, not only to locate the site of the brain injury, but far more important, to ascertain the presence or not of an increased intracranial pressure, whether that pressure be due to intracranial hæmorrhage or to cerebral œdema. As is well known, the fracture in these cases (if we exclude depressed fractures of the vault which should always be elevated or removed) is possibly the most unimportant part to be considered in the treatment, whereas the presence of a marked increase of the intracranial pressure, with or without a fracture of the skull, should immediately cause the patient to be withdrawn from that large group of patients properly treated by the expectant palliative method, and the advisability of an early operative procedure to relieve the increased intracranial pressure should be considered.

During the three years 1913, 1914 and 1915,* I examined and treated personally 239 adult patients having acute brain injuries with or without a fracture of the skull; in only 79 of these 239 patients (that is, 34 per cent.) were there marked signs of an increased intracranial pressure, and, therefore, only these patients were operated upon to relieve this increased pressure, whereas the remaining 160 patients did not show definite signs of an increased intracranial pressure, and were, therefore, treated by the expectant palliative methods of absolute quiet, ice helmet and catharsis; if in shock, then the routine treatment of shock. It is thus seen that only one-third of the patients having brain injuries with or without a fracture of the skull were operated upon, and approximately this same ratio has continued during the past year. It is this careful selection of patients not only in regard to the advisability of an operation or not, and if indicated, then the type of cranial operation used, but of the greatest importance—the ideal time for performing the operation—these factors have made it possible to lower the mortality of fractures of the skull from the average 50 per cent. of most hospitals to 30.7 per cent. at the Polyclinic Hospital, and if we exclude the moribund patients dying within three hours after admission to the hospital from

*"Journal of the American Medical Association," May 13, 1916.

shock, internal injuries, and in many cases the fracture of the skull being but an accident in the patient's general condition, the mortality is lowered to only 19 per cent.

In the treatment of brain injuries with or without fractures of the skull, if the patient is allowed to develop definite paralyses, a lowered pulse-rate, Cheyne-Stokes respiration and pulse and that appalling group of extreme intracranial pressure signs, then I agree entirely with the opinion so commonly now held that these patients "get along" just as well without operation as with operation at this late stage—the mortality being 50 per cent. and over; but patients with brain injuries should not be allowed to reach this dangerous stage of medullary compression due to the high intracranial pressure—it should be anticipated by accurate diagnostic methods now known, and if a marked increase of the intracranial pressure is ascertained, then an early relief of it should be advised, not only to save the life of the patient, but to lessen the post-traumatic conditions of changed personality either of the excitable or the depressed type, persistent headaches, early fatigue, occasionally epilepsy and that long train of post-traumatic conditions so frequent in brain injuries, and due in the majority of cases to a prolonged increase of this intracranial pressure.

Besides the lowered pulse and respiration rate, which are comparatively crude signs of intracranial pressure, and if of the irregular Cheyne-Stokes type, then most late signs of extreme intracranial pressure with its resulting medullary compression, the two most valuable procedures for determining a definite increase of the intracranial pressure are the examinations of the fundi of the eyes, with the ophthalmoscope and the measurement of the pressure of the cerebro-spinal fluid at lumbar puncture by means of the spinal mercurial manometer.

Although it is rare for a measurable papillœdema and "choked disks" to occur in these cases of traumatic intracranial lesions with or without a fracture of the skull, yet the earlier and, therefore, milder degrees of an œdema of the optic disks should be most carefully "watched for" with the ophthalmoscope as being one of the accurate signs of the presence or not of a definite increase of the intracranial pressure; the ophthalmoscope, and especially the direct method, is a most valuable means in the diagnosis of cranial lesions. Rarely do these fundal examinations reveal an increased intracranial pressure within six hours after the head injury; this is due to the presence of shock in these patients who later exhibit the marked signs of

intracranial pressure; as head injuries are usually accompanied by shock of varying degrees, naturally in these cases the blood pressure is low, so that even if a large intracranial vessel was torn, yet there could be only a comparatively small amount of hæmorrhage because the resulting increased intracranial pressure would soon be greater than this lowered blood pressure of shock, and, therefore, the bleeding would cease; however, as the patient recovered from the condition of extreme shock, then the blood pressure would rise, and now more bleeding could occur intracranially until the intracranial pressure would again equal the lowered blood pressure; finally, if the patient survived this condition of shock, then the blood pressure would be continuously greater than the intracranial pressure, so that this resulting increased intracranial pressure would produce its characteristic signs in the fundus of the eye—a dilatation of the retinal veins, and an œdematous blurring of the nasal halves, and if still higher, then an œdematous obscuration of the temporal halves of the optic disks; a measurable papillœdema and "choked disks" occur in these cases only when the intracranial pressure is extreme, due to a large intracranial hæmorrhage of slow formation, such as the extradural middle meningeal type—just as in brain tumors or when the ventricles are blocked producing an internal hydrocephalus; naturally, if the intracranial hæmorrhage forms very rapidly and of large amount, the patient usually dies within a couple of hours, so that "choked disks" have very little time to be produced; again, the shock following head injuries usually lasts for about six hours in the patients who survive and, therefore, it is rare within these first six hours for the ophthalmoscope to reveal definite signs of an increased intracranial pressure; it may be also noted that if the patients do not survive the condition of shock they usually die within the first six hours. It is, therefore, of the greatest importance to recognize these early signs of increased intracranial pressure by repeated ophthalmoscopic examinations, and to realize that these œdematous blurrings of the optic disks are more than being merely within physiological limits; it is true that in cases of myopia there is normally an obscuration of the disk outlines, but these patients can be excluded by the second and following test, which should always be performed.

The most accurate means now known for ascertaining the presence or absence of an increased intracranial pressure is the measurement of the cerebro-spinal fluid at lumbar puncture by

the spinal mercurial manometer. It is similar to a blood pressure apparatus, as safe as a lumbar puncture when properly performed, and by it the varying degrees of intracranial pressure can be carefully recorded. The normal pressure is 5-9 mm. of mercury, so that if a pressure higher than 15 mm. is obtained at lumbar puncture, then we know that the signs of intracranial pressure, as shown in the fundus of the eye, are confirmed. This method of estimating intracranial pressure is most important in the differentiation of the intracranial condition of spastic paralysis due to hæmorrhage at birth from those other causes of the so-called Little's disease. In other intracranial conditions producing the extreme stages of papillœdema and "choked disks," and even their end results of secondary optic atrophy as in neglected cases of brain tumor, naturally it is not necessary to confirm the ophthalmoscopic findings in order to make a diagnosis of an increased intracranial pressure. If, however, in these traumatic lesions of the brain, we must wait until a "choked disk" results from extreme intracranial pressure in order for us to state that the intracranial pressure is high, and if we must wait for the pulse-rate to descend to 60 and below, and the respiration and pulse to assume the irregular Cheyne-Stokes character of medullary compression, then undoubtedly the mortality of these patients will be 50 per cent. and even higher. Patients should not be allowed to reach this dangerous stage of medullary compression —this stage should be anticipated—and it can be by repeated ophthalmoscopic examinations and the measurement of the pressure of the cerebro-spinal fluid at lumbar puncture.

In selected cases of mild intracranial pressure due to trauma, very frequently the convalescence can be shortened, the headaches relieved and the general condition of the patient greatly improved by lumbar puncture, and if necessary repeated lumbar punctures; not only will the œdematous "wet" condition of the brain be drained in this way, but a prolongation of the increased pressure be avoided, and, therefore, the definite danger of post-traumatic conditions, so common in these cases, be lessened. Naturally, this method is only applicable to mild selected cases, and lumbar puncture should never be advocated as a means of drainage in patients having high intracranial pressure or in subtentorial lesions for fear of a consequent medullary compression in the foramen magnum.

We now come to the most important and the difficult question in the treatment of brain injuries with or without a frac-

ture of the skull. "If an operation is advisable, when should it be performed?" This question can more easily be answered by stating the two periods when the operation should *not* be performed. Naturally, we must exclude the majority (about two-thirds) of fractures of the skull who do not have a definite increase of the intracranial pressure, and, therefore, no operation is indicated. (The depressed fractures of the vault, naturally, should always be elevated or removed.)

The two periods in which an operation is distinctly contra-indicated in cases of brain injury are first, the condition of severe shock in the very beginning; and, secondly, the condition of medullary collapse—the death-knell of the patient. To advise a cranial operation upon a patient—no matter how badly the skull is fractured, nor how extensive the intracranial hæmorrhage seems, and that patient is in the condition of severe shock with a pulse-rate of 120 and higher, then the operation at that period of shock takes away whatever chance the patient may have of surviving the shock: the operation is but an added shock and merely hastens the exitus. No patient having a brain injury should be operated upon in this condition of shock; the mortality is most high, and if a patient does recover from an operation in this period of extreme shock, then he recovers in spite of the operation. Cranial operations for brain injuries in this stage of shock were frequently performed in the past and most disastrously, and thus operations were almost discredited in the treatment of brain injuries. The natural reaction following these early operations in the period of severe shock was to wait until there could be no possible doubt that the patient was going to die, unless, as was thought, a cranial operation was performed; that is, the patient was permitted to reach the period of extreme medullary compression—a pulse-rate of 50 and below, irregular Cheyne-Stokes respiration and pulse and profound unconsciousness, before a cranial operation might be considered. This is a most dangerous stage for these patients to reach, and it is doubtful whether recovery can occur even with an operation at this period—the mortality being very high. But if the patient has struggled through this period of medullary compression and finally reaches the stage of medullary œdema, when the pulse-rate begins to ascend quickly to 120 and higher, respirations become rapid and shallow—that is, the stage of medullary collapse, then we have the second period, when no patient should be operated upon—they all die —operation or no operation. I feel that if these two extremes

can be avoided and the latter of these, medullary collapse, can certainly be anticipated in the operative treatment of brain injuries and their signs cannot be overlooked, that the rational treatment from an operative standpoint depends upon the presence or not of a definite increase of the intracranial pressure, whether there is a fracture of the skull or not; in some of the most serious cases no fracture was present, either to be ascertained at operation, in the operated cases or at autopsy. The aid of the Rœntgen-ray is important in the treatment of these traumatic cases only in patients with doubtful depressed fractures of the vault, and in latent fractures of the skull, where the bump is so apparently trivial that the patient might not be so carefully examined and treated as the condition would warrant. On the contrary, no patient with high intracranial pressure should be obliged to wait "over night" or for a period of hours merely to secure a Rœntgen-ray picture of the skull; it is of no importance in the treatment of those acute intracranial lesions whether a fracture is present or not; if there is a high intracranial pressure as shown by the ophthalmoscopic examination and by the measurement of the pressure of the cerebro-spinal fluid at lumbar puncture by the spinal mercurial manometer, then a cranial operation is indicated to relieve this increased intracranial pressure both by enlarging the intracranial cavity and by the drainage of possible hæmorrhage and cerebro-spinal fluid; it is not so much a question of removing the hæmorrhage as it is of lessening the increased intracranial pressure, whether that pressure is due to hæmorrhage or œdema, the operative indication is the same; many cases of head injuries at autopsy have revealed no hæmorrhage at all—merely a "wet" œdematous swollen brain, but sufficient to cause medullary compression and the death of the patient.

If an operation is considered advisable to relieve the increased intracranial pressure, then the operation of choice is the sub-temporal decompression and drainage; if there are no definite localizing signs of the intracranial lesion, then the decompression should always be performed on the right side in right-handed patients in order to lessen thereby any possible operative damage to the adjacent motor speech area. In these cases it is not so important to remove the hæmorrhage as it is to offset its pressure effects. In cases of depressed fractures of the vault showing definite signs of a high intracranial pressure, it is better surgical judgment to precede the elevation or removal of the depressed area of bone by a sub-temporal decom-

pression so that when the depressed bone is removed there will be little or no danger of the underlying cerebral cortex being damaged by its protrusion through the bony opening; as the sub-temporal decompression exposes a comparatively silent area of the brain—a portion of the temporo-sphenoidal lobe—its protrusion and possible damage would not appear clinically, whereas a partial paralysis, impairment of sensation or of vision might occur, and frequently does result from operations performed over the more highly developed areas of the cerebral cortex. Besides, the sub-temporal route provides not only an excellent exposure of the middle meningeal artery and that portion of the brain so frequently involved in fractures of the skull, but it affords drainage to the middle fossa of the skull —the chief intracranial cistern—at its lowest point at the base of the skull; again, the thinness of the squamous portion of the temporal bone makes the operation a less difficult one technically. The vertical incision (and not the usual curved incision) should be used not only to render the operative hæmostasis more effective in that the trunk of the temporal artery is clamped at its lowest point at the very beginning of the operation, and, therefore, there is no bleeding from its branches; but this incision also permits the removal of the underlying squamous bone as far as is possible beneath the temporal muscle —a diameter of three inches—and yet the attachment of the temporal muscle to the parietal crest is left intact, so that a firm closure of its separated muscle fibres is assured; this is a most important point in cases of high intracranial pressure as in brain tumor where a cerebral hernia or fungus might result from an imperfect closure of the temporal muscle. The insertion beneath the scalp of silver and celluloid plates and other foreign bodies is to be most strongly condemned.

If the intracranial pressure is so high that the cerebral cortex tends to protrude through the bony opening, it is frequently wiser in selected cases to perform a similar operation upon the opposite side of the head immediately after the first operation; I have been obliged to do this in only 5 per cent. of the patients; they are the ones having a swollen œdematous brain—" water-logged," as it were, where the drainage of blood and cerebro-spinal fluid is slight and not sufficient to cause a marked decrease of the intracranial pressure; in some doubtful cases it is better judgment to wait one or two days, and even longer, before the second operation is considered advisable. The rubber tissue drains are usually removed on the first or

second day post-operative, and the hospital convalescence ordinarily requires at least two weeks. Naturally, these patients should not enter into their former active life for a period of three months and even longer; a too early return to the strain and stress of modern life predisposes them to many complaints—both subjective and objective; repeated examinations of the fundus of the eye and of the superficial and deep reflexes are here most important in estimating the physical normality of the patient.

The end results of patients having brain injuries with or without a fracture of the skull have been a most interesting study. It has become quite a common belief that once a man has had a fracture of the skull and then recovers, he is never the same person again. In 1912, I examined the records of three of the large hospitals of New York City during the decade of 1900-1910; the mortality of fractures of the skull was 46-68 per cent.; the mortality of the patients operated upon was 87 per cent.—this high percentage due undoubtedly to the operation being postponed until the extreme stages of medullary compression and œdema, and also to the fact that the operation performed was the "turning down" of a bone flap—a much more formidable procedure than a decompression—and then the bone replaced so that even the benefits of a decompression were prevented; besides, in many cases, the dura was not opened, and as the dura is inelastic in adults, therefore no adequate relief of the pressure could possibly be obtained. Of the patients, however, who were finally discharged as "well" or "cured," I was able to trace only 34 per cent., but of these 34 per cent. of the total patients found, 67 per cent. of them were still suffering from the effects of the injury—that is, two-thirds of them were not as well as before the injury; the chief complaints were persistent headache, a change of personality of the depressed or of the excitable type, and thus emotionally unstable, early fatigue making any prolonged mental or physical effort impossible, and thus the inability to work, lapses of memory, spells of dizziness and faintness, and even epileptiform seizures in a small percentage of them. In examining the hospital records of the patients having these post-traumatic conditions, it was most interesting to ascertain that these were the patients—and there were but few exceptions—who regained consciousness gradually after several days, and remained in the hospital for a period of four weeks and longer, whose charts made frequent mention of the severe headache and a low pulse-rate of 60,

and in some cases below 60—that is, the usual clinical signs of an increased intracranial pressure; an ophthalmoscopic examination had rarely been made. Many of these patients still showed the results of the increased intracranial pressure in their fundi and at lumbar puncture, and these were the ones upon whom a cranial decompression even at this late date caused a marked improvement; the operative findings were always associated with a "wet" swollen œdematous brain; many of the so-called post-traumatic neuroses are, in my opinion, frequently superimposed upon this definite organic basis as the result of the brain injury.

The treatment, therefore, of brain injuries should not be limited merely to the recovery of the patient, as far as life is concerned, but it should also be directed toward obtaining a normal individual—approximating as closely as possible the condition of the patient before the injury.

20 W. 50th Street.

# Editorials

## CARE OF INVALID SOLDIERS

We find the following official announcement was made in Ottawa, November 30th: "The Military Hospitals Commission, which has been charged with very full powers in connection with the care of returned soldiers, has found it is confronted with many serious problems. The number of men in its institutions has about quadrupled within a year, being at present about 11,000, with a probable increase before the new year to 15,000." It seems probable at present that the numbers may far exceed 15,000. We are very glad to learn that certain differences which existed regarding the proper functions of the Army Medical Corps and the Commission have practically disappeared, and that the two bodies will work together in perfect harmony in the future.

There is a general opinion that Dr. Alfred Thompson, M.P. (Lieut.-Col.), who has been for some time Medical Superintendent of the Commission, has proved himself to be a very competent officer.

We learn from the Ottawa despatch that he will receive, or probably before the time of writing has received, a staff appointment as Assistant Director for Medical Services for Invalids, under the Director-General of Medical Services, and that he will carry on his work, so far as the medical care of the invalids is concerned, with a staff selected from the C.A.M.C.

The Military Commission will continue to carry on its admirable work in the way of procuring and equipping the various kinds of hospital accommodation required.

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## HEALTH MATTERS IN ONTARIO

We learn from the Department that the results of the wide distribution of diphtheria antitoxin, free of charge to the profession and the public, shows very satisfactory results. During the month of November the Board distributed antitoxin to the value of nearly $4,000. The records show that in that month there were 432 cases of diphtheria, with 16 deaths, or 3.7 per cent., while in the same month last year there were 467 cases, with 28 deaths, or 6.1 per cent. There were also in the same month 188 cases of scarlet fever, with no death; 384 cases of measles, compared with 515 of a year ago; 142 whooping-cough, compared with 91; 101 tuberculosis, compared with 132; 14 cases of cerebral spinal meningitis.

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## THE DOCTOR AT THE FRONT

Colonel George Nasmith, C.M.G., of Toronto, who has come into prominence as a Medical Health Expert, has written a very interesting book on some features connected with the war. He generally speaks very plainly, as the following quotation will show: " As we tramped along towards St. Julien our attention was attracted to a greenish, yellowish

smoke escaping from the part of the line occupied by the French. We wondered what the smoke was coming from half a mile up the road. We sat on a disused trench and lit cigarettes. Soon near a French line we saw this greenish, yellowish cloud rising on a front of at least three miles and driven at a height of perhaps one hundred feet towards us. The gas rose in great clouds, expanding as it escaped. Here and there brown clouds seemed to be mixed with the general yellowish-green ones. 'It looks like chlorine,' I said, 'and I bet it is.'" What Doctor Nasmith did in the way of fighting against this noxious gas is well known in Canada.

## FOOD POISONING

Food poisoning or, as it is sometimes called, ptomaine poisoning, is not exclusively from animal products. It has certainly been discovered that canned vegetables are frequently dangerous through the absorption of the toxin of bacillus botulinus. This poisoning frequently causes botulism, which is an intoxication, not an infection. Home canned vegetables and fruits are often more dangerous than those prepared commercially on a large scale, because the use of steam under pressure in canning factories affords protection against the bacteria.

# Editorial Notes

## ONTARIO MEDICAL COUNCIL

The following candidates passed the final examination of the College of Physicians and Surgeons of Ontario, November, 1917: Adam Ardill, Blind River; Elliott Nichol Ballantyne, London, Ont.; William Elmer Berry, Madawaska, Ont.; Harold Austin Boyce, Harrowsmith, Ont.; James Sinclair Crawford, Sarnia; Thomas Francis Delaney, Sault Ste. Marie, Ont.; Harold Tremain Jost, Ottawa; Leo. J. Murphy, Ottawa; Alvin James McKay, Woodstock; Harold Chester Nash, Stoney Creek, Ont.; Lorne William Nixon, Richmond, Ont.; Hugh James Porter, Freeman, Ont.; Gordon Earle Richards, Toronto; Charles Vincent Scott, Toronto; Offley Jackson Shore, Glanworth, Ont.

## TORONTO'S MEDICAL REPRESENTATIVE IN THE DOMINION HOUSE

Hearty congratulations to Dr. Charles Sheard on his election in South Toronto by a majority of over three thousand. His friends were all delighted, and at the same time thought he well deserved the honor. He graduated M.B. in 1878, and his success for years after as a teacher and practitioner in medicine is well known. He came especially into the public eye when he was appointed M.O.H. for Toronto in 1893, and acted in that capacity with distinguished success up to 1910. After that he occupied many offices with distinction, and took an active interest in public matters. A few years ago he was formally asked by a largely-signed requisition to be a candidate for the Mayoralty, but refused. We wish him success in the Dominion Parliament, but that seems needless, because his great ability, combined with his common sense and good judgment, have prevented him from failure in the past, and will, we are sure, continue to do so in the future.

# News Items

## SUBSTITUTES FOR BUTTER

Butterine is prepared from beef and hog's fat. Oleomargarine is a similar preparation made from beef fat. Both are wholesome fat foods, and the only objection to them is that they have often been sold for butter. Oleomargarine has come into common use in the United States and Great Britain. It will also be used in Canada, with the distinct understanding, however, that there shall be no fraud of any sort in connection with its use.

## THE HEALTH OF PRINCE ALBERT

The physical condition of Prince Albert, second son of King George, has caused a certain amount of uneasiness in Great Britain during the last three or four months. He has been for several years an officer in the British Navy. In August, 1914, he was removed ashore suffering from appendicitis, and was operated upon at Aberdeen. He has been on duty intermittently since then. He was again invalided from the Fleet in the latter part of the Summer, and was said to be suffering from the symptoms of duodenal ulcer. Early in September the report came from Buckingham Palace that his health was much improved. Shortly after that it was stated that he suffered a relapse, and a cablegram, dated November 29th, stated that he had been operated on for duodenal ulcer with satisfactory results. The official Court Bulletin announced the following day that his condition was "satisfactory."

# Personals

Dr. Edna M. Guest, formerly of Toronto, who went over to England a few years ago, was recently appointed C.M.O., Scottish Women's Military Hospital in Corsica.

We are glad to learn that Lieut.-Col. R. M. Simpson, C.A.M.C., of Winnipeg, is now C.O. No. 1 Canadian General Hospital in France.

Capt. W. B. Shaw, C.A.M.C., wounded over a year ago in France, is still unable to return to the front, but is acting as C.O. Military Hospital, Victoria, B.C.

Capt. Armstrong, C.A.M.C., after some months of service at the front, has returned to Canada, and is now C.O. Military Hospital, Moose Jaw, Sask. His two decorations, the Military Cross and the Croix de Guerre, indicated that he did some good work while in active service.

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Many of those in Canada who have visited Old Richmond in England are greatly interested in the Star and Garter Home in that town, which is intended as a permanent home for disabled and helpless soldiers and sailors who are unable to get skilled nursing which they require in their own homes. Only those are admitted that are considered totally and permanently disabled. It is encouraging to learn that out of 112 of those who were admitted supposedly for the rest of their lifetime, 18 have left the hospital "improved," and five others have shown such marked improvement that they were quite able to walk without assistance. We presume that most of our readers know that this was once the Star and Garter Hotel, which was one of the most popular public inns in England.

# Obituary

## BRIG.-GEN. BERNARD J. W. IRWIN, M.D.

Dr. Irwin died at his country home in Cobourg, Ontario, December 15th, aged 87. He was a distinguished representative of the Medical Department of the United States Army, taking a very active part in his younger days in the Civil War. He devised the first field tent hospital for the treatment of wounded on the battlefield at the time of the Battle of Shiloh, and this still remains the type of the most modern field hospital. For some years he had been living at Cobourg.

## SIR L. STARR JAMESON, M.D., LOND., M.R.C.S.E.

"Dr. Jim" Jameson, as he was called in England, and Cecil Rhodes were in their day the greatest British Imperialists, although perhaps the name of Chamberlain should be added. Jameson was born in Edinburgh, 1853, graduated M.B., London, and became M.R.C.S.E. in 1875. After two years of hospital work he became M.D., Lond., in 1877. On account of poor health he soon went to South Africa, where he became closely associated with Rhodes. The dry climate suited him and he soon became strong. For some years he had the best medical practice in South Africa, with an income of about $50,000. At a certain time he went into politics, and he and Rhodes conceived the idea of a United South Africa under the British flag.

In 1891 Dr. Jameson was appointed Administrator of Rhodesia, the colony which he did so very much to establish. In the year 1895 he, with the assistance of many merchants, and probably with the knowledge of Cecil Rhodes and Joseph Chamberlain, organized the celebrated Jameson Raid, which had for its object the overthrow of the Kruger Government in the Transvaal. The Johannesburg British failed to rise, as was expected, and Jameson's army was quickly surrounded, and after some heavy fighting Jameson surrendered. After a trial in England, he was sentenced to ten months' imprison-

ment. He was liberated in seven months. He suffered but little in person so far as reputation was concerned, as he was probably the most popular and the most dearly beloved man in Great Britain. He returned to South Africa after his release, and in a short time became the Premier of Cape Colony, and although he was ousted from that position by General Botha, his personal popularity continued to be great, and no man did more than he to help to heal the wounds produced by the South African War. He was made a Knight Baronet in 1911. He died recently at the age of 64, and his body now lies by the side of his great friend, Cecil Rhodes, the man known to many as the Colossus of British Imperialism.

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## WILLIAM T. FITZSIMMONS

We are told by the *N.Y.M.J.* that the first American in khaki who died for democracy is Lieut. W. T. Fitzsimmons, of Kansas City, Mo., Adjutant of the Hoover Hospital Unit. He was killed by a bomb dropped on his hospital in France by German airmen, Sept. 9th. The Journal goes on to speak of him as a brave youth murdered by a German bomb while going out as errant of mercy.

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## G. P. GIRWOOD, M.D.

Dr. G. P. Girwood, of Montreal, although scarcely known to the present generation of doctors, was for many years recognized as one of the ablest, most scientific and most popular physicians of Canada. We are told by the *C.M.A.J.* that he died at his home in Montreal, October 2nd, aged 85. He received his education at University College and St. George's School of Medicine, London, and became M.R.C.S., Eng., in 1854. After serving for a time as House Surgeon in the Liverpool Infirmary, he became Assistant-Surgeon of the Grenadier Guards, and accompanied the First Battalion to Canada at the time of the Trent affair in 1862. In 1864 he retired from the Army and commenced practice in Montreal. In 1869 he became a lecturer in chemistry, and in 1879 Professor of Chemistry, which Chair he held until 1892. His

illness lasted six years, during five of which he was blind. He was confined to his bed during ten months before his death.

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## RAYMOND GUITERAS, M.D.

Dr. Raymond Guiteras, New York City, Harvard Medical School, died on December 13th in New York, from meningitis, aged 57. He was a well-known urologist, big game hunter, and a great traveller. He had made a host of friends in Canada as well as in his native land, and had an international reputation.

He visited Toronto many times, and only a short time ago gave an address at the Academy of Medicine. He was the author of a standard text book on Urology; a most charming and versatile man; a Prince of good fellows, and a Prince of our art.

# Book Reviews

*A Manual of Anatomy.* By Henry Erdmann Radasch, M.Sc., M.D., Assistant Professor of Histology and Embryology in Jefferson Medical College; Instructor in Anatomy in the Pennsylvania Academy of Fine Arts, Philadelphia. With 329 illustrations. Philadelphia and London: W. B. Saunders Company, 1917.

This appears to be an excellent manual for junior medical students and nurses, and others for whom too much detail is not desirable. Throughout the book the B.N.A. nomenclature is given in parentheses, and the author subscribes to the view that it is a system of nomenclature by no means ideal, with which we would agree.

In his discussion of the nervous system and some of the circulatory system the author is original in his handling of the question.

The illustrations are mostly adapted from other standard works, but several are from preparations at the Daniel Baugh Institute of Anatomy and Biology.

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*History of Medicine.* Suggestions for Study and Bibliographic Data. By Fielding H. Garrison, A.B., M.D., Principal Assistant Librarian, Surgeon-General's Office, Washington, D.C. Second edition, revised and enlarged. Octavo of 905 pages, with many portraits. W. B. Saunders Company, Philadelphia and London, 1917. Cloth, $6.50 net; half morocco, $8.00 net. Sole Canadian agents, The J. F. Hartz Co., Ltd., Toronto.

The appearance of the second edition of Dr. Garrison's "History of Medicine" would indicate that the stimulus which the publishing of the first edition gave to the study of the history of medicine has resulted in the awakening of the medical profession to the importance of the subject. In the past, as is stated, French and German sources have given the chief support to the study. Among English and American physicians it has been, with a few exceptions, a much neglected subject. This possibly has been due to the lack of a guide to point out the proper methods of approaching what has been almost a new study.

We would not attempt to criticize the work. To read it has been a delight and a lesson. The subject is presented in a most interesting manner, and not the least important of

the contents are the appendices, in which suggested plans for studying the history of medicine by small reading clubs or groups of students are given. Every man should have a hobby. What better hobby for the physician than the study in his leisure hours of the history of the profession to which he belongs?

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*Food for the Sick.* A Manual for Physician and Patient. By Solomon Strouse, M.D., Associate Attending Physician, The Michael Reese Hospital; Professor of Medicine at the Post-Graduate School, Chicago, and Maude A Perry, Dietitian at the Michael Reese Hospital, Chicago. 12mo of 270 pages. Philadephia and London: W. B. Saunders Company, 1917. Cloth, $1.50 net. Canadian agents, The J. F. Hartz Co., Toronto, Ont.

A good practical work on dietetics is an absolute necessity to every practising physician, since medicine has begun to take notice of things outside the pharmacopœia. The authors have succeeded in making an excellent and readable volume, which we heartily commend.

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*Notes for Army Medical Officers.* By Lieut.-Col. T. H. Goodwin, R.A.M.C., author of Notes for Medical Officers on Field Service in India, and Field Service Notes for R.A.M.C. With an introductory note by Surgeon-General William C. Gorgas, U.S.A. Illustrated. Lea and Febiger, Philadelphia and New York, 1917.

This convenient pocket-size manual is Medical War Manual No. 2, and is authorized by the Secretary of War, and under the supervision of the Surgeon-General and the Council of National Defense of the United States. It is a splendid book for battalion medical officers, and, in fact, is the outcome of the lectures delivered by Col. Goodwin at the Army Medical School in Washington, and embodies the results of the experiences of medical officers on the Western Front.

There are four divisions dealing respectively with Organization and Administration, War Surgery, Sanitation in War, and an Appendix containing general notes and useful hints.

This is certainly one of the best war manuals we have seen. It is clear, concise, without a single superfluous word, and it is personal, from the pen of one who has lived and worked under active service conditions.

# Reports of Societies

## ACADEMY OF MEDICINE, TORONTO—STATED MEETING FOR NOVEMBER

Professor Irving Fisher, Professor of Political Economy at Yale University, addressed the Academy of Medicine, Toronto, at its meeting on Tuesday evening, November 6th, upon the subject of Health Insurance.

He pointed out the ill-effects following the failure of the working man to insure himself against sickness, whereas the wealthy man insures himself against accident, illness and death, against fire, burglary and other damage. The poor man rarely has protection. The great proportion of poverty in this country is due to illness in the household, the loss of wages, and the expenses due to illness impoverish the man whose savings are scanty. Investigations of the Buffalo Charities Organization Society within the past two or three years have shown that of the cases of poverty they have had to deal with, 78 per cent. have been caused by illness.

Health Insurance will not only provide a remedy for this poverty, but will be a great stimulus in preventing disease. As boiler inspection has all but eliminated the former large number of accidents due to explosions, so will Health Insurance arouse a healthy interest in the causation of disease, whether due to long hours, poor ventilation, careless habits, indiscriminate expectoration, protection against dangerous trades and processes, or other factors in the morbidity of working men. Simple rules of personal hygiene will also be impressed upon men and women, who will become interested in the scheme as they become contributors to the same.

During the past few years the average age at death in America has increased five years. Practical hygiene has accomplished this. Yet if the figures be closely studied, it will be found that this average has been increased through the lessened number of infant deaths. Children formerly dying in the first and second years of life are now being carried on to six, eight and ten years of age. We are preventing the acute infectious and nutritional disorders which formerly caused a high mortality in infancy, but these are only

carried on for a few years. On the other hand, the period of productive life has not increased. We have not prolonged life during the working years. In fact, the life expectancy at forty-five has not increased; while at fifty it has appreciably lessened during the past two decades, and at age sixty it has materially lessened. We have now to combat the degenerative diseases of middle life as we have combated the infections of early life. Our problem is well illustrated by the fact that of 10,000,000 conscripts of age 21 to 31 recently examined in the United States, it is stated that some 60 per cent. have been rejected as medically unfit. A more careful survey was made of 1,000 employes of the Ford Motor Company, and of 1,000 bank and office workers in New York, by the Life Extension Institute. Of these 2,000, 99 per cent. were found to have minor or major defects ranging from carious teeth and nasal obstruction to hypertension, albuminuria and glycosuria. And these were a class definitely above the average of their age and station in life.

We have to face now the loss of life due to degenerative diseases of middle life, and must now seek the remedy, which lies in prevention. With these diseases prevention must begin early, for they as a rule develop but slowly. A Health Insurance will go far to lessen these diseases.

There was a good attendance, and Professor Fisher's audience gave him a most appreciative hearing.

Dr. D. J. Gibb Wishart, the President of the Academy of Medicine, occupied the chair, and a hearty vote of thanks was proposed by one of the Past Presidents, Dr. Albert A. Macdonald, seconded by Major J. G. Fitzgerald.

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**Wanted to Know Bad**

A young fellow who has not long been married usually confides his troubles to a friend whose matrimonial experience covers a period of many years.

One day the former remarked very despondently:

"I said something to my wife she didn't like, and she hasn't spoken to me for two days."

The eyes of the old married man brightened.

"Say," he exclaimed, eagerly, "can you remember what you said?"

# Selections

## Exophthalmic Goitre

Case No. 1645, F., aged 38, Journalist. This patient had had a "full neck" since childhood, but little attention was paid to it, and no treatment adopted. During the last year she had suffered from steadily increasing mental fatigue, was quite unable to concentrate her attention, and was excessively nervous. She was much troubled by palpitation of the heart, and became very breathless on exertion. Operative measures had been considered, but interdicted. The patient was first seen on March 12th, 1915. She was a tall woman of spare figure. There was a moderate degree of uniform enlargement of the isthmus, and both lobes of the thyroid gland, the greatest circumference of the neck being 36 cm. The gland moved freely on deglutition. No eye symptoms were present. There was a fine tremor of all the limbs, aggravated by voluntary movements. Pulse rate 146. Patient weak, restless and excitable.

She was treated from March 15th to 29th inclusive, receiving in all thirty hours' exposure with applicators containing 250 mgr. screened with 2 mm. of lead, and disposed over the gland in such fashion as to procure a "cross fire" irradiation. Patient was next seen on May 4th. She stated that the thyroid commenced to shrink rapidly ten days after her treatment terminated, and that at the end of three weeks it was very much smaller. This shrinking, however, had been accompanied by an exacerbation of all her symptoms, the tremors becoming more marked, the pulse rate quicker, and the exhaustion and restlessness more pronounced, so that for a period of three weeks she was much worse than she had ever been. During the last fortnight she had been improving, and now felt considerably better.

Examination showed the thyroid gland to be much smaller, the circumference of neck being now 33 cm. Pulse rate 122. Tremor lessened but still evident. Patient was very nervous and depressed. She was advised rest, quiet, and good feeding, but no further radium treatment; and asked to report again in five or six months. She came again on September 19th. She had made steady progress, the gland had not increased in size. Pulse rate 92. Tremor scarcely noticeable. She was much

more restful, less nervous, and no longer depressed. She slept well and was putting on flesh.

She received a further eighteen hours' treatment with applicators containing 200 mgr. screened with 2 mm. on October 25th, 26th and 27th. No further improvement was recorded in her condition, though on the other hand, there was no relapse.

Early in 1916 she decided to submit to operation, and this was accordingly performed, the greater part of the gland being removed.

The surgeon who operated expressed the opinion that the previous radium treatment had contributed greatly to the successful result.

Case No. 1718, F., aged 31. This patient gave birth to her first child on August 9th, 1914. Three months later she sustained a severe nervous shock.

Tremor and tachycardia developed shortly afterwards, soon followed by swelling of the thyroid gland, but the eye symptoms did not appear until early in 1915.

She was first seen on May 7th, 1915. There was then a general swelling of the thyroid gland most evident on the right side, the circumference of the neck being 36 cm. Proptosis was definite and noticeable, but not great. Both Von Graefe's and Stellwag's signs could be elicited. There was a fine tremor of the hands on voluntary movement. The heart's impulse was forcible, and the pulse rate varied from 140 to 160 per minute. There was marked hyperidrosis. Patient was not irritable, but exceedingly restless, and unable to concentrate her attention.

She was treated from May 17th to 21st inclusive, receiving six hours' exposure each day with flat applicators containing 200 mgr. screened with 2 mm. of lead, placed over and around the thyroid gland.

Slow, but steady and distinct improvement resulted from the treatment, and in January, 1916, the patient's medical man wrote, saying that all the nervous symptoms had gone, the thyroid was no longer enlarged, and the proptosis was scarcely appreciable. The pulse-rate was normal, the hyperidrosis and extreme restlessness had disappeared, the patient had gained fourteen pounds in weight, and was living a perfectly happy and useful life.

No further treatment has been required.—*Report of the Radium Institute, London.*

**Simulation of Disease**

In an epitome of current medical literature on this subject, the *British Medical Journal* of July 17, 1917, after quoting the unsatisfactory study of the psychology of simulation, alludes to artificial skin eruptions of which pustulodermatitis is the most common, these lesions being gathered together in patches, mostly placed on the hairy parts of the face, often on the ears and neighboring parts, or on the front and left surfaces of the thigh. An important diagnostic point is that the pustules are all in the same stage of evolution. For the production of these eruptions croton oil and thapsia are chiefly used. Artificial phlyctenular dermatitis is not common. Milian states that automobile oil will sometimes produce lesions suggesting at first sight an erysipelas. Œdema is produced by tying a wide flat strap on the forearm or the lower part of the leg during the night. Artificial ulcer is not readily identified. Persistent ulcer in a young man, otherwise healthy, is probably artificial. These sores are not in the usual position for chronic ulcers. They are commonly on the legs at places within reach of the patient's right hand. They may be caused by a blister or a caustic agent. If the patient be an old syphilitic diagnosis from gumma may be difficult. Artificial mucous patches are produced by the lighted end of a cigarette. They make lesions on the left side, situated on the inner surface of the lower lip not far from the commissure, in the cheek, or on the velum, never on the pillars of the fauces or the tonsils.

Carruccio notes that he has seen more than a hundred soldiers with an acute dermatosis of practically identical nature. These lesions were produced by the application to the skin of vegetable substances, such as pounded roots of Daphne gnidium and the juice of the cactus leaf. When rubbed over the entire body they caused a somewhat intense erythema.

Ascarelli states that one of the most common forms of lesions inflicted on themselves by Italian soldiers are abscess and phlegmon, produced by injection of petrol, turpentine, benzine, chloride of lime in benzine solution, etc. They most commonly select the lower limbs, often the calf, the instep, and sides of the knee, sometimes the buttocks. The patient appears shortly after the injection, ascribing the swelling to a fall or a twisting of the part or to a contusion. There is always slight albuminuria, without casts. At times there is

emphysematous crepitation. An incision shows comparatively little pus. Sometimes abscesses are produced by injection of fæcal matter. There results a deep phlegmon accompanied by grave sepsis.

Gradenigo states that artificial otitis is fairly common. As a rule the effects produced are suppuration, exceptionally perforation of the membrane. Caustic is used in such strength as to produce destructive inflammation. The complications at times are serious.

Van Schevensteen observes two types of conjunctivitis—one produced by powdered ipecacuanha, the other by agents of very various kinds which produce anomalous lesions. The introduction of ipecacuanha causes intense injection with chemosis, with slight secretion. The reaction subsides in a few days, but the mucous membrane long retains the salmon tint which reveals the origin of the lesion. Ectropion with lacrimal stasis may result from repeated applications.. Eosinophilia, according to Bollack, is noted in the cytological examination of the secretion, and is characteristic in the artificial affection although it comes on late. Castor-oil seed is used to produce conjunctivitis.—*Therapeutic Gazette.*

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**Fatigue and Alcohol**

In the *Lancet* of July 28, 1917, Kent thus concludes a sane discussion of this subject:

It appears, then, that the taking of alcohol has little immediate effect upon the physical side of fatigue, whatever its ultimate result may be. The amount of output may perhaps be increased to a small extent for a time, but the increase soon falls off and is replaced by a diminution. The influence of alcohol upon the psychical side of fatigue is more profound. It leads immediately to a feeling of renewed vigor and increased strength. But here also the effect is transitory, and repeated doses must be taken if anything lasting is required.

If we look at the other side of the question and ask, What is the influence of fatigue upon the taking of alcohol? the answer is clear. Fatigue, as we understand it, involves physical discomfort. The worker knows full well that this discomfort can be diminished by drink. What more natural than that he should turn to it? Because the effect is tran-

sitory the dose will be repeated again and again, and industrial alcoholism will be established.

Ordinary drunkenness is diminished amongst us, and we can afford to ignore its occasional appearance if we can destroy the infinitely more harmful industrial drinking. The problem should be placed upon a new basis. It should no longer be regarded merely as an industrial evil to be deplored or to be treated by an appeal to its victims; it is a scientific problem to be solved by an appeal to the laws of cause and effect. Too long has it been treated with reference to symptoms only. Let it be treated on scientific lines, let the *cause* of intemperance be attacked, and let the attention which the great war has drawn to the lot of the worker bring to him the greatest possible blessing.

The data are sufficient for a solution to be reached. Alcoholism follows industry, but its severity is dependent upon the conditions of industry. Conditions determine fatigue; fatigue induces men to drink. Clearly, therefore, our attack must be on conditions. Where conditions have been improved fatigue and drinking have diminished.

The true cure for alcoholism is the provision of decent surroundings in the factory and in the home, adequate wages, leisure and relaxation, clubs, recreation rooms, indoor and outdoor games—in short, the elements of a healthy, full and interesting life in place of a mere existence without interest, without pleasure, and without hope.—*The Therapeutic Gazette.*

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### Treatment of Broncho-Pneumonia in Children

Measham, in his article in the *London* (Eng.) *Practitioner* says that broncho-pneumona in small children is a condition which is all too frequently seen, both in general and hospital practice. Thus says the writer, in the seventh edition of his "Principles and Practice of Medicine," Osler states that "the death-rate in children under five has been variously estimated at from 30 to 50 per cent." Flemming, in his "Short Practice of Medicine," says "probably over 50 per cent. of patients under the age of three terminate fatally." This is a large death-rate, and any method of treatment which holds a prospect of reducing it is well worthy of consideration.

The method of treatment which I have adopted in seventeen cases is as follows: The child's chest is enveloped in a

light Gamgee jacket, and over this a pair of woolen combinations are worn. The bed is placed in a part of the room free from draughts, and not more than the usual amount of bedclothes is used. A fire is kept constantly burning, and the window always open. The child is encouraged to take frequent sips of cold water. No medicines are given by the mouth, but a subcutaneous injection of quinine hydrochloride is given morning and evening. A solution is prepared in which one grain of the quinine salt is dissolved in ten minims of water, and the dosage is as follows:

For a child under six months .....Mv.
For a child under one year .....Mx.
For a child under two years .....Mxv.
For a child over two years .....Mxx.

The treatment is simple to carry out, and the hypodermic method has obvious advantages in dealing with small patients.

A striking feature is the rapidity with which physical signs of the disease disappear, the patient often appearing in normal health ten days after the first injection. It is not claimed that the use of quinine hydrochloride in bronchopneumonia in children is in any way original, but I have not seen it mentioned in any of the text-books, and it does not appear to be commonly used in general practice.

The series of cases, 17 only, is a small one, but I think it is large enough to show that the treatment advocated is of undoubted use, and may allow us to take a more cheerful outlook in a disease which has hitherto been a source of grave anxiety.—*American Medicine.*

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**How He Knew**

A Christian Scientist came across a small boy sitting under an apple tree doubled up with pain.

"My little man," he said, "what is the matter?"

"I ate some green apples," moaned the boy, "and, oh, how I ache!"

"You don't ache," answered the follower of Mrs. Eddy; "you only think so."

The boy looked up in astonishment at such a statement, and then replied in a most positive manner: "That's all right; you may think so, but I've got inside information."

# Miscellaneous

**Camphor in Cardiovascular Disease** (*Policlinico*).

P. Marfori regards camphor as a useful drug in small doses for dilating the vessels to reduce the blood pressure in both the greater and the lesser circulation. It stimulates the heart and regulates the pulse in cases of chronic myocarditis with simple cardiac insufficiency, with arrhythmia, or with auricular fibrillation. Camphor has an almost elective action on the right heart. When the heart is compelled to work harder on account of increased resistance in the respiratory domain, as in the pulmonary sclerosis of the tuberculous, camphor should be given. It is also useful in cases of high arterial pressure from hypertrophy of the heart or vascular spasms, as with arteriosclerosis, or the high pressure of the menopause. It should be given systematically, over long periods, either by subcutaneous injections of camphorated oil, one or two a day, each equal to 0.1 gm. of camphor, or in pill or other form by the mouth.—*The Prescriber.*

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**Palliative Treatment of Inoperable Carcinoma of the Cervix by Radium**

Without making any claim that permanent results have been obtained, R. T. Frank (*Jour. Cancer Research,* 1917, ii. 85) reports twelve cases of carcinoma of the cervix treated with radium. He says that radium is our best palliative measure in inoperable carcinoma of the cervix. Far advanced cases may be treated with radium. It not only rapidly relieves the pain, hæmorrhage, and discharge, but, indirectly also improves the general health and condition. The minimum quantity of radium substance needed is 50 mgm. "Border line" cases or operable cases should be submitted to operation after a short preliminary course of radiation. Good primary results may then be expected from simple total hysterectomy. Operated cases should be subjected to post-operative prophylactic radiation, beginning not later than four weeks after operation. The technic of radium treatment of cervical cancer is simple and easy to learn. Judging from the limited penetrating power of the rays and the variation of resistance

of different cancers, it seems probable that numerous disappointments will occur, and that in many cases positive harm will be done by enthusiasts who refuse to submit operable cancers to surgical operation.

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**Eusol Injections in Children** (*Edinburgh Medical Journal*).

J. Lorrain Smith, J. Ritchie, and T. Rettie, in a report to the Medical Research Committee, show that eusol can with safety be injected intravenously. They have tried its effect so given in the treatment of the toxæmia forming part of the symptoms of ordinary bacterial infections in children. The infections which were benefited by the method include lung infections, broncho-pneumonia, empyema, toxic diarrhœa, appendicitis, and chronic meningitis. No benefit was obtained in cases of rheumatism, chorea, and tuberculosis. The success of the application depends essentially on the reaction of the patient: the benefit may be either direct through the destruction of circulating toxin, or indirect in the sense of stimulating a protective reaction. Standard eusol was employed, one c.c. of which is equivalent to one c.c. 1-10 normal sodium arsenite solution, and the dose varied from 10 c.c. to 75 c.c. When eusol is cautiously administered no untoward effects follow.—T. S., *The Prescriber.*

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**Sarcoma of the Prostate in a Boy Aged 4½ Years**

(Arch. de Med. dés Enef.)—B. de Saussine, G. Bertrand and H. Androtsellis report the course of the disease as insidious at first, being characterized by some difficulty in micturition and pollakiuria, followed by colicky pain in the hypogastrium. About a fortnight after the onset complete retention developed. Ascending infection of the urinary passages ensued owing to repeated catheterization and death took place. The autopsy showed a tumor the size of a mandarin orange surrounding the prostatic urethra, purulent cystitis, and a slight degree of pyelonephritis. On microscopical examination the tumor was found to be a fibrosarcoma with myxomatous degeneration in places.—*The British Journal of Diseases of Children.*

# Encouraging the Nutritive Process

In patients whose digestive and assimilative powers have become so weakened as to respond scarcely at all to food stimuli, it becomes necessary to restore the blood-making organs to their normal efficiency, if a successful issue is to be obtained.

In such cases every encouragement should be given the Nutritive Process, in the way of easily digestible food, which, at the same time, is nourishing to the organs themselves, as the foundation of the body in general.

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**Canadian Postum Cereal Co., Ltd., Windsor, Ont.**

P.—4

### The Recovery from La Grippe

Since the first appearance upon our shores of that unwelcome infectious disease known as La Grippe, the medical journals have been filled with articles advocating different methods of treating the attack itself and its various complications. But little attention, however, has been paid to the important question of how to best treat the convalescent subject. Among all of the acute infections there is probably none that is as likely to leave the patient quite as thoroughly devitalized and generally prostrated as does a sharp attack of La Grippe. For some reason the degree of prostration from grippal infection appears to be entirely out of proportion to the severity of the attack itself. This peculiarity renders it advisable and usually necessary to strengthen and support the general vitality of the patient during the period of convalescence. Complete rest, nourishing food, plenty of fresh air and stimulation according to indications are, of course, distinctly important measures. At the same time tonic and hæmatinic medication should not be neglected. Probably the most generally acceptable and efficient general tonic and hæmic reconstituent for such patients is Pepto-Mangan (Gude), a bland, non-irritant and promptly absorbable combination of the organic peptonates of iron and manganese. This efficient blood builder and reconstructive does not disturb digestion nor induce constipation, and is readily taken by patients of all ages.

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### The Catheter

The catheter, unskilfully or carelessly employed, is a dangerous instrument, and before its use it is better where there is retention of urine to resort to all palliative measures first, as hot sitz baths, suppositories of belladonna and opium, hot rectal injections and colonic flushings, and to the administration of sanmetto in teaspoonful doses every hour for first three or four hours, and then every two hours until reasonable time for relief. Never withdraw the entire amount of urine at once, as it might be followed by hæmorrhage from the bladder or kidneys or a complete suppression of urine, ending fatally. Always follow urethral or bladder instrumentation with irrigation or injections of the milder silver salts, and the administration of sanmetto to soothe and relieve the irritation or inflammation of the urinary canal.

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in addition to possessing Tonic properties, acts as a restorative and aids starch-conversions. It is rapid in action, highly nutritious and more palatable than ordinary tonics. The use of "Wincarnis" is indicated in all cases of Convalescence from severe illnesses—especially after Influenza—in Anaemia, General Physical Weakness and in the Aged—in cases of Wasting or Inanition such as Phthisis and other tubercular affections. As a Nerve Food "Wincarnis" is most useful in cases of Neurasthenia and other Nervous Disorders.

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### Treatment of Enuresis in Children

*Med. Jour. South Africa,* 1917.—C. L. Leipoldt emphasizes the importance of thoroughly examining every case of enuresis in children. The patient should be stripped, weighed and measured, examined for deviations from the normal so far as the skeletal system is concerned, while each system should be tested in turn, and any defects carefully noted and considered. In dealing with cases of enuresis, hygienic and educative measures are very necessary, and if they are part of the treatment it will generally be found that all simple cases, *i.e.*, those without congenital malformation, respond rapidly and readily to atropine, theobromine, or thyroid extract. It is essential that atropine should be pushed, in heroic doses, until its physiological effects are obtained. If tincture of belladonna is used, twenty drops three times a day should be the commencing dose, and should be increased to a drachm, given thrice daily. If this treatment be not effective, quinine theobromate in 5 grain doses twice or three times a day, or thyroid extract in full doses, may be tried. The most intractable simple cases one sees in girls. For such, most drastic measures, such as cauterisation of part of the urethra—have been recommended, but it is a useful point to remember, where a child suffering from enuresis resists treatment for any length of time, that the condition may really be due to an unrecognized congenital defect, and that it is proper to have such a child examined under the X-rays.—*The Prescriber.*

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### London's Dug-Outs

The air-raids over London have brought into use many underground places in public buildings and warehouses that have been left for long years unused except for the storing of lumber. It is only natural that people in poor districts, thickly congregated together, should leave their small tenements or large model dwellings and seek a place where they are comparatively secure from any missile. But there is also the graver question as to the effect a stay in these ill-ventilated places may have on the health of the people, especially of babies and young children. A visit to a number of the basements used in the south parts of London show great overcrowding, little or no ventilation, and a thorough

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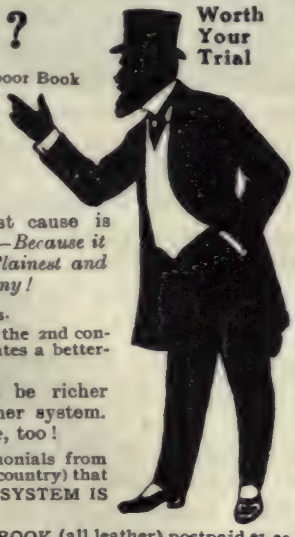

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lack of any lavatory accommodation. One can better imagine than describe what such a place is like after being inhabited for a length of time with women standing together in close formation with children in their arms. The stench is revolting, and after they have gone it has been found necessary next day thoroughly to disinfect and cleanse the buildings. Happily, it is anticipated that Londoners have seen the worst of these air-raids, and, if that be so, then these unpleasant conditions will soon be over. One striking feature of these public dug-outs is the almost entire absence of anything approaching fright or consternation even under the most trying circumstances. For instance, in one large town hall, where some 1,500 people nightly take shelter, on one occasion when a raid was in progress the electric light suddenly failed. The people remained absolutely quiet until a number of oil lamps were produced from the adjoining works. And this occurred amongst very poor people, who are generally credited with being apt to create a panic in an emergency.—*The Hospital.*

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### The Evolution of Emetine Treatment

The story of the various steps that have led to the use of emetine in dysentery forms a romantic chapter in the history of medicine. For over a century ipecacuanha was employed empirically in the treatment of this disease; it gave splendid results, but the concomitant nausea was a serious drawback to its use. Some five or six years ago Leonard Rogers discovered that its alkaloid, emetine, had a lethal effect on the amœba responsible for a certain variety of the disease; he tried emetine hypodermically and obtained perfect results. So far, so good, until the question arose of relapses and of carriers. Hypodermic emetine would not touch the encysted amœba, which lay dormant until a favorable opportunity, when it emerged and reproduced the disease. Moreover, emetine in some cases causes toxic effects of its own before it effects a cure.

The problem as it stands at present is to find a salt of emetine that can be administered by the mouth without disturbance of the stomach. For this purpose a salt insoluble in the stomach but soluble in the intestine is desirable. Emetine bismuth iodide fulfils this condition to a certain extent,

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but it seems to be soluble in some stomachs, for it frequently causes vomiting. Methyl-emetine sulphate has been tried, but has not proved superior to emetine hydrochloride.

It ought surely to be possible to produce a salt of emetine to fulfil the necessary conditions. The phosphotungstate has been suggested, but it is feared that the liberation of phosphotungstic acid may prove prejudicial. At present no other salt has been suggested. The opportunity is an excellent one to test other salts of the alkaloid, and research chemists might with advantage experiment in the production of insoluble salts on the lines of emetine bismuth iodide in order that these might be tried on the numerous cases of amœbic dysentery now in our military hospitals.—*The Prescriber.*

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### Personal Experience with the Extract of Corpus Luteum

Happel, in the *Interstate Medical Journal,* expresses his belief that the extract of corpus luteum is the most effective remedy for menstrual irregularity in young women and for the relief of nervous symptoms which usually accompany it. It is a specific in certain cases of headache and should be tried when the ordinary remedies fail. It prevents the development of the symptoms of postoperative menopause and relieves those of the natural climacteric. It is useful in the treatment of sterility and sexual anæsthesia and should be tried in hyperemesis gravidarum. Certain cases of dysmenorrhœa are cured by it.—*The Therapeutic Gazette.*

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### The Effect of Sunlight Upon Repair of Fractures

Neuhof (*Interstate Medical Journal,* August, 1917), conducted a number of laboratory experiments on rabbits exposed to sunlight, being led to this line of work by the brilliant results incident to this form of therapy in cases of open and joint tuberculosis. The rabbits were placed on a roof, receiving the same care and attention. The members of one group were exposed daily to the sunlight, and the other were screened from the sunlight, the screen being arranged to avoid any interference with the air supply. In the specimens from the sunlight animals there was almost invariably

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a much broader and more vascular zone of activity at the fracture ends, and earlier and more vigorous osteogenesis between the two fragments. In not a single instance was there greater activity of repair in the control. The controls demonstrated normal repair as ordinarily seen after experimental fracture; the "sunlight" animals presented hyperactivity of repair.—*Therapeutic Gazette.*

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**Sulphur in Vaginitis** (*Practitioner*).

Francis Philip Gill draws attention to the difficulty in curing vaginitis. The normal protectors of the vagina are the squamous epithelium and the normally acid secretion due to lactic acid. In disease both are absent, on account of ulceration and the alkalinity of the discharges. The author describes two cases, both of which were treated with sulphur in the form of ointment (precip. sulphur, 2 ounces; soft paraffin, 4 ounces). Precipitated sulphur is better than flowers of sulphur, which is gritty, and the B.P. sulphur ointment is too weak.

A piece of lint 2 inches wide and 12 inches long is thickly coated on one side with the ointment and introduced between the cervix and the posterior fornix. This is done night and morning, preceded by a good vaginal douching of warm water and soap. In the case of uterine or ovarian pain the same ointment can be plastered over the hypogastrium. Sulphur has a great affinity for hydrogen, and the resulting sulphuretted hydrogen penetrates deeply into the affected tissues, acting as a germicide. It is better than curetting or the application of strong germicides like carbolic. The ordinary routine treatment of vaginitis is confessedly unsatisfactory, and this simple procedure is of high value in producing vaginal antisepsis.—P. A. H., *The Prescriber.*

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In Inflammatory Diseases of the Skin, especially where volumetric analysis shows defective urinary elimination, sanmetto will be found a useful remedy, owing to its direct action on the kidneys.

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"Is your husband subject to draft?"

"Yes, indeed. He catches cold at the slightest thing."
—*Detroit Free Press.*

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## Original Communications

### POLIOMYELITIS


By Capt. H. W. Hill.

D.A.D.M.S. i/c S., M.D., No 1; M.O.H., London, Can.; Director, Institute of Public Health, London, Can.


Gentlemen:—The prevalence of poliomyelitis last year gives not unreasonable grounds for expecting it this year, and for expecting it to appear more particularly in those localities not greatly affected last year. True, we can give no very clear account of why we hold this belief, it is empiric at best, like nearly everything connected with the epidemiology of this disease.

Expecting it, however, as we do, the rational thing is to prepare for it as best we may, considering how little we know even yet of its sources or methods of spread.

Suppose to-morrow a case is reported to you. What should you as health officer do? You should, I think, see the case, or at least secure certain details beyond the mere name, sex, age and address—particularly you should find out the date of earliest symptoms; the whereabouts of the patient during the two weeks preceding the onset; the presence or absence of paralysis; when it occurred, if it is present, in relation to the date of earliest symptoms; and the existence or otherwise of other similar cases preceding, accompanying or following the reported case.

The next steps are, the isolation of the case for six* weeks, the observation of those contacts who are children for two weeks, and immediate report to the Chief Health Officer of the Province of your findings in full.

I think myself that these procedures cover the maximum that should be done of a compulsory nature. A pretty concentrated experience of the epidemiology of poliomyelitis extend-

* Two or three weeks, according to Com. of Conf. of State and Prov. Boards, U.S.P.H. Reports, May 18, 1917.

ing over several years, from 1908, and a continued interest in the subsequent observations of other epidemiologists to date, lead me to believe that almost all the other measures for restriction proposed, and sometimes carried out under pressure of public panic, are useless and damaging.

Amongst the hysterical measures, of absolutely no avail, I would mention, first, the closing of the public schools. This measure is put up to the health officer during poliomyelitis outbreaks, usually with regard to opening the schools in the fall rather than closing them in the spring, because the disease is more often prevalent in the fall term than in the spring term. If we are to be governed by horse sense and evidence, not by blind unreasoning fear, we will not put off the opening of the schools, even by one day, on account of poliomyelitis; first and most conclusive reason of all because all the evidence we have on the subject shows that the opening of the schools corresponds, as a rule, with a diminution, not an increase, in the cases; second, and less important, but worth remembering, because the incidence of poliomyelitis and its fatality is greatest in children not of school age, and, therefore, is not affected by school closing; third, and least important but somewhat comforting, because the opening of the schools gives an opportunity, to be had in no other way, of watching the children of school age and discovering mild cases, etc., otherwise overlooked.

If, however, you must close the schools, remember that you must close Sunday schools, moving-picture shows, and all other meeting places of children also, or place yourself in an absurd situation only to be made more absurd if you *do* close those places, for there is plenty of evidence that poliomyelitis will and does spread in rural communities in summer when there are no schools, moving-picture shows, etc.

The extreme measures employed in certain localities last year while disrupting the ordinary life of the communities involved, showed no evidence of producing even the smallest results in restricting the disease, and personally I think that prohibition of travel for all under sixteen, keeping all these at home day and night, etc., are and have shown themselves to be quite fallacious. Of our three local cases in London last summer, one was a school boy attending school, but the other two were sequestered, one an eighteen months old child, the other a boy of six, whose parents had restricted him to their own backyard entirely, with the very object of escaping the disease. Taking the children away from the epidemic area seems equally fallacious. I need hardly remind you of the well-

known case of a prominent State Board of Health Secretary, who removed his four children to a very exclusive summer resort in order to escape the city epidemic, and lost two of them by death from the disease, developed while at the resort. I, myself, have seen similar instances; in one instance the only two cases that developed in a certain rural community were in the persons of the two children of a rich man who, in fear of the disease, had isolated them with a trained nurse in his own estate.

When we turn from the problem of legal control to the equally perplexing problem of advising, the many who will ask this summer what is best to do in various situations, I am accustomed to admit that from the depths of my ignorance I can only advise, without knowing whether the advice is any good, three things:

First: Keep the children as quiet, cool, well-fed and content as you can, avoiding over-exercise and excitement.

Second: Have a physician see any child showing any indisposition, however slight, that involves fever, or sore throat, or upset digestion, or pain in limbs.

Third: When one or more children show such symptoms give all round a dose of five grains hexamethylenetetramine three times a day, and spray noses and throats with lemon juice and water, equal parts, filtered so as to pass through an atomizer.

Turning to the developed case, therapeutics, fortunately, is a matter with which the health officer has no direct responsibility. But advice is often asked, and my own is as follows:

First: Should the case go to the hospital? I think this should be decided on the basis of where the best facilities are to be had for keeping the patient quiet and content, unless necessity for catheterization or similar expert attention becomes necessary.

Second: Should any form of serum treatment, electric treatment, or other special treatment be used during the acute stages? My own idea is that nothing but supervision of the main functions of the body should be attempted during the acute stages, and I do not know of any evidence conclusively in favor of any form of special treatment as yet.

Third: How soon should be begun the later treatment of a case which has passed the acute stages? In my opinion, not for six weeks in most cases, and even longer if pain or tenderness continue. Electricity is useless except in the hands of experts, and even then in but few selected cases. Special muscle training is the great desideratum.

## RADIUM IN TUBERCULOSIS OF THE SKIN*

By Dr. W. H. B. Aikins, Toronto.

Tuberculosis of the skin assumes various forms, the most common being Lupus Vulgaris. It also includes a group of cutaneous eruptions known as tubercolides, all of which, according to Sequiera,[1] exhibit the following characteristics:

1. They appear in a tuberculous subject who reacts to tuberculin.
2. The eruption is usually bilaterally symmetrical.
3. The histology suggests tuberculosis.
4. Most of the cases tend to spontaneous recovery.
5. Koch's bacillus is generally absent.
6. Inoculation of the guinea-pigs is seldom successful.

Several hypotheses have been suggested from time to time to explain the ætiology of these tuberculous lesions, some have assumed that they represent a reaction of the skin to a toxæmia due to a pre-existing tuberculous focus; others that they are due to the presence in the circulation of dead tubercle bacilli, whilst a third asumption is that they are due to emboli consisting of bacilli of a low degree of virulence. Rist and Rolland[2] base a new hypothesis upon an extensive series of experiments on guinea-pigs. Human and bovine tubercle bacilli were injected intradermically into these animals one to four months after subcutaneous or intraperitoneal injection of similar organisms, the secondary inoculations invariably resulting in symptoms of tuberculosis. They conclude that these tuberculous lesions are due to endogenous re-inoculation of an individual in whom there is already present an active or latent tuberculous focus, and believe that this view is confirmed by the fact that in such cases a positive cuti-reaction to tuberculin is invariably obtained.

*Lupus Vulgaris.* This is the most common form of tuberculosis of the skin. Its most frequent site is in the face, more especially the nose and adjacent tissues, but it may occur on any part of the body. It often develops on the operation scar after removal of tuberculous cervical glands.

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* Read at meeting of Canadian Medical Association, Montreal, June, 1917.

Knox[3] is of the opinion that, from the point of view of treatment, each case of lupus should be judged on its own merits, as in some instances radium appears to be the best possible form of treatment, whilst others respond best to x-rays, and others again to treatment by the mercury vapor lamp. As a routine treatment for this disease the Finsen Light is, in my opinion, greatly to be preferred to radium, but where it fails to effect cure or improvement, radium sometimes proves of great value. Unscreened exposures of one or two hours' duration should be given until a destructive reaction is produced. The resulting scar is unusually firm, smooth, supple and inconspicuous.

Brockært[4] discusses the treatment of lupus by radium, which he thinks has not taken its proper position in rhinolaryngology. It has been found most useful when the disease affects the cavities, such as the nasal cavity and the larynx, which are more or less difficult of access by other therapeutic measures. Brockært is in the habit of using special applicators with flexible handles, suitable for insertion into either the nose or larynx (in the latter case shaped like a laryngeal mirror), covered with rubber caps, and in some cases with an aluminum envelope as well. In his paper he gives full details of the technique, and seems to have considerable confidence in the efficacy of his method if the directions given are closely adhered to.

There do not appear to be any very extensive statistics in literature in regard to the treatment of lupus by radium. Danlos[5] who in 1901 reported seven cases of lupus vulgaris with good results, was the first to attempt it, and in the following year three cured cases were reported by Blandamour.[6] In 1910 Barcat[7] reported two cases treated by radium with good results, one of lupus of the nose, and another of lupus of the nose and cheek, the lesions healing in the latter case within two months after a single application of radium.

In 1911 Wichmann[8] reported 30 cases of lupus, treated either by radium alone or in combination with other measures, many of which had remained without recurrence for four years, and in the following year he reported 112 cases with 44 cures (39.3 per cent.).[9] Jungmann[10] reports a case in which lupus of the ala nasi has remained without recurrence for two years, and Dantwitz[11] two cases, in one of which the lupoid focus on the face was 6cm. in diameter. Cure resulted, and

when seen two and one half years later there was no recurrence. In the other cases extensive lupus of the face in a girl of fourteen was cured, with a good cosmetic result.

Professor Haslund[12] of the Finsen Light Institute, Copenhagen, has treated 31 cases of lupus vulgaris of the face by radium, sometimes associated with Finsen Light treatment, x-ray treatment or electrolysis. Six cases were cured, in one of which cure has persisted for two and a half years. Although in his opinion radium is inferior to Finsen Light treatment, he thinks that his results show that it is possible to obtain healing and permanent cure by it in certain cases in which the disease is not extensive. Dr. Benham Snow[13] states that he has had uniformly successful results from radium treatment in his cases of lupus vulgaris, provided that they are not so far advanced that tissue destruction is very extensive.

Schramek[14] uses a combination of radium and drug treatment, and claims that it produces better results than the use of radium alone. Two to three spoonfuls of a solution of iodide of potassium or iodide of sodium are administered internally about an hour and a quarter before the first irradiation. (It has been shown experimentally that by this time most of the drug will have reached the circulation). He gives fairly strong radiation, using a silver filter of 0.07 millimetres, covered by a layer of gutta percha, the time of application varying from one to two hours. Before giving a second application he waits for complete subsidence of the reaction, the administration of iodides being continued. He has treated eight cases with clinical cure, and thirty cases which are still under treatment give promise of a successful result. No lupoid infiltration can be demonstrated in the cicatrices left after the radium treatment, and the cosmetic result in the cured cases is especially good. Some of these last cases were very severe and extensive. He believes that the elective influence of radium upon tuberculous cells is increased by a combination with the iodides, and that necrosis occurs much more rapidly than in non-iodised tissues with a similar apparatus and duration of radiation. His cases were kept under observation for over a year after healing had occurred.

Lupus erythematosus is generally regarded as distinct from tuberculous lupus, but it often occurs in tuberculous subjects, especially women, and the serum of those suffering with it agglutinates the tubercle bacillus. It is intractable to most forms

of treatment, but considerable success has attended the use of radium. Wickham and Degrais[15] state that in their experience radium has given very satisfactory results, whilst no other form of treatment has proved effective. This applies to the chronic form of the condition. Dr. Frank Simpson[16] reports ten cases, varying in severity from small patches to the involvement of a considerable part of the face. He gives exposures of from thirty to forty minutes in the first place, followed a few days later by two shorter ones of from ten to fifteen minutes. In all the cases there was marked improvement, and five of them remained well and free from recurrence when last seen. He finds that the chronic or fixed form of the condition is best treated by destructive doses of radium.

Abbe, of New York has also had surprisingly good results where the lesions were extensive and many of great chronicity.

Sibley[17] says that in his experience considerable improvement usually occurs in lupus erythematosus. He recommends the use of an applicator of a quarter to half strength, the rays being either unscreened or screened with 0.01 mm. of aluminum, and the duration of the exposures varying from forty minutes to an hour. It is necessary to continue the treatment for a prolonged period at frequent intervals.

Dawson Turner,[18] in the Report of the Edinburgh Radium Institute, reports a case in which several isolated areas in the scalp were affected with lupus erythematosus. The condition has proved refractory to other forms of treatment, including the x-rays, but apparent cure resulted from a dose of 10 milligramme hours of radium to each of the patches. He applied full doses with unscreened apparatus to the margins of the patches and the tissue a little beyond them, and when last seen the skin had become perfectly healthy and soft.

Dr. Douglas Heath[19] discusses the possibility of the development of malignant tumors on the scar of healed lupus vulgaris. He reports a case in which sarcoma developed on the scar of old lupus of the upper lip and nose, recurring rapidly after two operations and treatment by x-rays. Under cross-fire radium it diminished in size and ultimately fell off. Radium was applied to the base of the tumor, and when seen four months later there was no recurrence. In his opinion radium is more efficacious in this class of case than any other form of treatment.

Dr. Riddell[20] reports the development of an epithelioma on

the scar of lupus of the right temple of twenty-five years' standing, which had been treated by the x-rays. Two applications of radium resulted in complete healing, and when last seen there had been no recurrence.

*Scrofuloderma.* Scrofuloderma usually involves the skin over breaking down scrofulous glands, infection being due to the underlying tuberculous focus. It may also occur near fistulæ due to tuberculosis of bone. Breaking down of tuberculous glands may lead to the formation of sinuses, from which the skin is secondarily infected. Scrofuloderma occurs most often in children and young people, but exceptional cases are met with in elderly people. Wickham and Degrais believe that radium is of great service in this condition, provided the cases are carefully selected. Where the tissues are deeply infiltrated and ulcerated they recommend unscreened radiations of great intensity.

*Verculosis.* Wickham and Degrais found radium very beneficial in this wart-like form of tuberculosis of the skin. They recommend the use of more or less penetrating rays, stronger and more destructive doses being employed than in ordinary lupus. Simpson reports two cases. In one, a man aged thirty-five, there was verruca necrogenica of the third finger of the right hand, which completely disappeared under radium treatment. In the second case, which is still under treatment, the lesion was associated with enlargement of the cervical glands, and the results so far are encouraging.

Verculosis may be due to auto-inoculation with the tubercle bacillus in those who are suffering from tuberculosis, but is more common in doctors and others attending such patients, and those who come into contact with the bodies of those who die from the disease.

*Tuberculous Ulcer.* Acute tuberculous ulcer usually occurs only in individuals suffering from visceral tuberculosis, and is generally associated with enlargement of the lymphatic glands.

*Tuberculosis of Glands.* In cases in which surgical measures have been declined for cosmetic reasons radium often proves of considerable value, either when used alone or as an adjunct to vaccine treatment. In such cases it is advisable to give heavily screened exposures of thirty or more hours' duration, and when practicable an effort should be made to secure

"cross-fire" radiation. If the glands are caseating, radium treatment is of very little use.

Knox states that while tuberculous glands usually diminish in size and become quiescent under radium, they very rarely entirely disappear, and are likely to become active again after a longer or shorter interval. He therefore is of the opinion that operation should be considered when the disease becomes latent, and radium applications given subsequently with the object of preventing recurrence. In view of the frequency with which the thoracic glands are involved in these cases, he recommends that these glands also should be treated by radium.

In the Report of the Radium Institute, London, for 1913[a] two cases of tuberculous glands are referred to. In one, a woman aged 24, two tuberculous glands had been operated upon, and afterwards treated by "cross-fire" radium. Under the treatment they were reduced to very small hard nodules, and have given no further trouble. In the other case tuberculous glands were fixed by the scar of an old sinus. Under radium they were reduced to the size of shot, and became movable under the skin. The scar was scarcely noticeable. Hayward Pinch states that prolonged exposures from twenty to thirty hours' duration in all, with a heavily screened apparatus, generally cause progressive reduction in the size of the glands.

*Tuberculous Sinuses.* The difficulty which is frequently encountered in obtaining healing of the sinuses persisting after removal of tuberculous cervical glands is well recognized. In several of such cases it has been found that radium treatment, carried out by the insertion of a powerful tube of radium directly into the sinus, has been most successful in bringing about the destruction of the diseased tissue, and in stimulating the development of healthy granulations, ultimately resulting in general obliteration of the diseased focus. Schramek has found the combination of drug and radium treatment, which has been previously referred to, very beneficial in these cases.

The following cases may be of interest:—

Case I.—A nurse 52 years of age came under observation in May, 1911, with a tuberculous ulceration of the left nostril, which she stated had developed ten years previously. Various kinds of local treatment had been tried, including caustics, electrolysis, curettage and the x-rays, but the condition con-

tinued to progress. When she came to me there was involvement of the margins of the nostrils, resulting in the projection of a fungating ulcerated nævus from about the nasal orifices. On the nose and adjacent portion of the cheek were several typical lupus nodules.

Her appearance was greatly improved by radium treatment carried to a point sufficient to cause destruction of the diseased tissue. The ulcerated areas healed, and although the nose had been destroyed to such an extent that a certain amount of permanent deformity existed, the further progress of the tuberculous process was arrested. And the report at the present time is that the condition is quite satisfactory.

Case II.—A young woman, aged 26, had a definite lupus ulceration of the left cheek, which had first developed five years before coming under observation. She described it as a "cold sore," which would not heal. A destructive exposure of radium resulted in complete disappearance of the ulcer, with complete healing.

Case III.—A woman, 43 years of age, presented a patch of lupus on the right cheek. It was roughly oval in shape, measuring 1¾ x 2¼. Twenty-five years previously she noticed a small spot of discoloration, which gradually extended centripetally leaving an area of scar tissue in its centre. This central area was surrounded by a thickened zone of a pinkish yellow color, which on pressure under a glass slide exhibited the "apple jelly" appearance so characteristic of lupus. The treatment adopted in this case was destructive dosage of the radium rays. This resulted in the disappearance of the thickening of the tissues, leaving a scar, slightly paler than the normal skin. In this case trichloracetic acid was used with good effect for the treatment of isolated patches of lupus.

Case IV.—A patient, aged 29, stated that she first noticed lupus on the right side of the nose five years previously. She had treatment by the x-rays, caustics, and carbon dioxide, but in spite of these measures the lesion continued to spread, and when first seen all the skin of the nose was more or less involved. It presented a patchy appearance, owing to the fact that a certain amount of healing had taken place, leaving pale and atrophic scar tissue on the margin of which the tissue was raised and of a reddish yellow appearance. She had radium exposures on three occasions with very great benefit, as the tissues are becoming normal in color, and the thickening has disappeared. This case is still under observation.

### Scrofuloderma.

Case I.—Six months previously the patient, aged 42, noticed three or four pimples on the left side of the cheek. These gradually increased in size until, at the time when the first case came under my observation, there was a patch, four and a half inches in length by one and a half inches in width, covered by warty nodules on a scarred base. The picture was that of typical scrofuloderma. Radiations were given of sufficient intensity to produce a severe reaction, the result being a slow, but progressive, disappearance of the lesions, the site of which has now become perfectly smooth.

Case II.—A boy of fifteen exhibited a chronic ulceration of the right cheek, quite typical of scrofuloderma. From the ulcer, which was about the size of a five-cent piece, a sinus passed in an upward direction for two inches, the skin over it being of a dusky blue color. The lesion had followed a "pimple" which had been noticed about two years before.

The sinus was treated by incision and curettage, and the involved area of the skin by exposure to radium. Six weeks later the ulceration had completely healed.

Case III.—A girl, twelve years of age, exhibited tuberculous infection of the skin over the upper part of the sternum, which had been present for over a year. A certain amount of spontaneous healing had already taken place, but the centre of the scarred area stil showed a patch of ulceration, measuring ½ inch x 1 inch. The ulcer had a sluggish base, with ragged undermined edges of a dark purplish tint.

Under radium the extent of the ulceration markedly diminished and there is every indication that it will soon be completely obliterated.

### Verculosis.

Case I.—A colleague of mine, who cut his finger when opening a bottle of tuberculous sputum, subsequently developed a tuberculoma of the "post-mortem wart" type. Exposure to radium rays of sufficient intensity to produce a marked reaction rapidly brought about its destruction, with subsequent healing of the lesion.

Case II.—A lady, aged fifty-eight, had suffered for ten years from a tuberculous infection of the nail of the first finger of the left hand. The nail had been removed, but the infection still persisted. Pale, unhealthy-looking granulations, from below

FIG. 1.

FIG. 2.

which pus could be made to exude by pressure, covered an area three-eighths of an inch in diameter. The condition responded satisfactorily to radium treatment, and the lesion has now quite disappeared.

### Acute Tuberculous Ulcer.

Case I.—The patient was a girl, aged seventeen, who consulted me on December 3rd, 1914. She stated that an appendicectomy had been performed in January, 1914, and that at the operation the appendix was found to be tuberculous. Four or five days after the operation small papules, which subsequently ulcerated, were observed on the dorsum of the right hand. These healed some weeks after. Papules then appeared on the anterior surface of the right wrist and the dorsal surface of the index finger of the right hand.

When she first came under my observation these also had undergone ulceration. Five small ulcers about three-eighths of an inch in diameter, with irregular outlines and undermined edges of a dusky purple color, were scattered over an area on the wrist, which was about two inches square. A similar ulcer was present on the index finger and on the sole of the left foot. In this case the association of the tuberculous ulcer with visceral tuberculosis was quite obvious.

Treatment by applications of radium over the ulcerated areas, in combination with general tonic measures, resulted in healing of the ulcers in about six weeks' time.

Case II.—In April, 1916, a dental student, aged twenty-two, while on active service abroad with the Canadian Army Dental Corps, noticed a pustule at the junction of the cheek and ala nasi on both the right and the left sides. He incised the pustules, but they did not heal. Under instructions from his Medical Officer he tried various ointments without healing taking place, and as a matter of fact the ulceration progressively extended. On returning home to complete his College course he was referred to me for treatment by Dr. J. S. Graham. When I saw him there was present at the right ala nasi an oval ulcer ¾ inch x ½ inch in extent, with an irregular base, presenting unhealthy granulations and thin slightly elevated edges. At the left ala nasi was a similar, but smaller ulcer, about the size of a five cent piece.

The von Pirquet reaction was positive. The history of this case appeared to indicate fairly conclusively that in the

FIG. 3.

FIG. 4.

course of his dental work among the troops the patient had inoculated himself locally with the tubercle bacillus.

Radium treatment was undertaken, sufficiently intensive to produce a marked reaction, and resulted in satisfactory healing of both the ulcers, the smaller one being healed in six weeks' time. The larger ulcer required a second exposure before complete healing was produced.

Case III.—The patient, a man aged thirty-two, presented an irregularly ovoid ulcer on the chin, measuring 1¾ inches x 1 inch. This had developed one month previously on a nodule which had been present for five months, and had undergone necrosis. The edges of the ulcer were sufficiently clean-cut to suggest the possibility of luetic origin, but this was contra-indicated by the fact that a Wassermann reaction proved negative. Exposure to radium resulted in gradual healing.

Case IV.—A girl aged seventeen, the daughter of a colleague, came to me with a history of the development of a number of papules on the forehead and nose, which subsequently ulcerated. Electrical treatment had no effect. When referred to me for radium treatment there was a large number of papules on the forehead and nose, some of which were undergoing necrosis and breaking down. Exposure to radium sufficient to produce a marked reaction, brought about a marked improvement in the appearance of the lesions, but as fresh nodules continued to develop it was decided to try the effect of subcutaneous inoculations of tuberculin. It was found that 6 to 8 minims of B. E. 1 in 20,000 produced both a systemic reaction, as evidenced by slight pyrexia and headache, and a focal reaction, shown by some erythema of the affected parts. By giving a dose of tuberculin weekly, sufficiently small to avoid such reaction, gradual improvement in the condition was brought about. Fresh papules ceased to appear, and the skin resumed its normal appearance. This improvement has now persisted for some months.

Case V.—A boy aged three and a half years,[23] was treated by radium for a tuberculous ulcer on the dorsum of the right hand. It had been present for two years, and had been treated by iodine, caustics and other measures. Two patches of ulceration, measuring nearly half an inch in diameter, slightly elevated and of a dark color, were situated close to one another. Radium treatment was commenced on December 3rd, 1912, and continued for a fortnight, the total dosage amount-

ing to 20 milligramme hours. A screen of aluminum only was employed. A month later the patches of ulceration were covered by a good scab, which fell off at the end of January. By this time the lesions had almost completely disappeared, but to make the cure more certain a further dose of 13 milligramme hours was administered.

The writers on the subject seem to be practically unanimous in the opinion that radium is an important and valuable addition to the therapeutic measures employed in tuberculosis of the skin. In considering the question of absolute cure, however, it should always be remembered that the local lesions may be only the expression of a systemic disease, and the possibility of recurrence should be borne in mind. This being so it is scarcely necessary to emphasize the necessity of keeping a close watch on the apparently cured cases for a prolonged period, in order that relapses, if they occur, may be dealt with at an early stage.

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134 Bloor Street, West.

# Editorials

## ACCOMMODATION FOR RETURNED SOLDIERS

According to reports received from the Military Hospitals Commission, January 23rd, there is no shortage of hospital accommodation for returned soldiers. There are now 1,170 beds vacant, with no immediate prospect of filling them. These beds are provided as follows: Cobourg 400, Whitby 160, Burlington 200, and Guelph 400. Within a short time there will be available also 480 beds at Whitby, 300 in Toronto, and it is probable in the near future a hospital with 600 beds will be erected in London. From these figures it would appear that there is no immediate urgency for building a new Military Hospital, with 1,040 beds, at High Park, Toronto.

We shall still continue, probably, to have small detachments of returned soldiers coming regularly from overseas. What will happen after the opening of hostilities in the spring no one can say, but the Military Commission, in conjunction with the Army Medical Corps, are endeavoring to prepare for serious contingencies.

Since the above went to the printer we learn that the statements therein contained are incorrect, or at least misleading. It appears to be one of the remnants of the old disagreement between the Hospitals Commission and the C.A.M.C. As announced in our last issue, Lieut.-Col. Thompson, M.D., Medical Superintendent of the Commission, is now working as Assistant Director of Medical Services in hearty

co-operation with his chief, General Fotheringham; but certain mischief-makers are trying to create trouble, the worst of them being apparently a Mr. Armstrong. It certainly seems remarkable that this man, who has considerable ability and good working capacity, should become such an obstacle to anything like smooth sailing, and also such an unmitigated nuisance from a medical standpoint.

According to the latest rumor, January 28th, the Military Hospitals Commission has decided to purchase the Cash Registry Factory, with seven acres of land, Christie and Dupont Streets, Toronto, with the hope that ultimately it will have a capacity for 800 or 900 beds.

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## PREVENTION OF TYPHOID IN THE CANADIAN ARMY

Some may feel inclined to belittle the work of our Army Medical Corps, but we believe we are justified in saying that all who have studied its work carefully are greatly pleased with the results up to the present time. Nothing has been more satisfactory in connection therewith than its preventive work against typhoid fever. It has practically made inoculation compulsory without any exceptions, and we are not quite sure that that has been accomplished by any other army in the world. The British made it as generally compulsory as possible from their lights, but when certain men absolutely refused they did not force them. When Canadian soldiers objected their officers accepted no refusal. They did not exactly tie them to whipping-posts or use any violence in any way, but by a combination of firmness and kindness

they always accomplished their point. As a consequence typhoid fever has found fewer victims proportionately in the Canadian army than that of any other country on either side in the war. We are sorry to learn from the *New York Medical Journal* that they have certain troubles about this matter in the United States, where we learn with astonishment that such a magazine as *Life* is putting up a persistent campaign against the practice of vaccinating soldiers.

## THE HALIFAX DISASTER

The calamity which befell our beautiful city of Halifax, December 6th, 1917, was the most appalling of its kind that this country has known. The local doctors commenced service immediately and did magnificent work for the sufferers. Col. (Dr.) J. W. S. McCullough, C.O.H., Ontario, and Mr. Dallyn, Sanitary Engineer, Ontario, were sent at once by the Government of Ontario to give a helping hand. They remained four days and rendered material assistance from a sanitary standpoint. Colonel (Dr.) Marlow, of Toronto, also went to give what assistance he could to the C.A.M.C. We are pleased to mention that Miss Eunice Dyce, from the staff of Doctor Hastings, M.H.O., Toronto, did splendid work in the way of organizing the Nursing Department in the stricken city. On the evening of December 7th, Sir John Eaton, after loading his private car with food and supplies of various sorts, started for Halifax, taking with him two members of the staff of the Sick Children's Hospital.

## THE STUDENTS OF LAVAL UNIVERSITY

A remarkable story came to us from Montreal in the latter part of January. The students of Laval University, who unfortunately have not proved to be loyal to the British Empire for some time past, are now endeavoring to escape conscription, and, to get evidence for the appeal tribunals have gone to civilian doctors. Of 177 students examined by these physicians, 164 have been pronounced physically unfit for military service; 40 suffered from tuberculosis; 27 from nephritis; 26 from diabetes; 32 from heart trouble; 14 bronchitis; 18 flat feet, and 10 deformities. Some of our newspapers are disposed to be humorous and declare that Laval is not now a teaching university, but has become a sanitarium. Unfortunately it is not a joke, but a very serious matter. Without discussing the matter in detail we may say that it has been conceded for ages past that from a professional point of view nothing is more contemptible (to put it very mildly) than the dishonesty of physicians who deliberately issue false certificates. It might be well for our Canadian Medical Council to consider this matter very seriously.

## CANADIAN NEW YEAR'S HONORS

Among members of the C.A.M.C. are the following, decorated with C.M.G.: Brigs. Ernest Asheton, M.D., and Hugh Griesbach; Colonels Wallace Scott, M.D., Geo. Rennie, M.D., John Amyot, M.D., and Edouard Panet, M.D., D.S.O.; Lieut.-Colonels

Alfred Basin, M.D., Percy Bell, M.D., James Davey, M.D., Chas. Dickson, M.D., James Fraser, M.D., Thos. Leask, M.D., Walter Moodie, M.D., Chas. Peters, M.D., and Clifford Reason, M.D.; Major Geo. Mothersil and Capt. Gordon McLarty.

Knighthood has been conferred upon Dr. Andrew MacPhail, of Montreal, who is described as "editor, essayist and commentator on things in general." Major MacPhail, who although perhaps best known in Montreal and Toronto, is well known and popular with the profession in all parts of Canada. He was born in Prince Edward Island in 1864, but since boyhood has lived most of the time in the city of Montreal. He received his medical course at McGill, and after considerable post-graduate study in London, visited Spain, Italy, Egypt, China, and Japan. Sir Andrew recently spent a few weeks on leave in Montreal, and returned to England, December 15th.

Sir William J. Gage, of Toronto, is another of the new knights. He was born in Peel County, and was for a time in his earlier years a student in medicine, and although he never graduated, he always took a very active interest in that profession. He was best known, however, in his philanthropic activities, and particularly in connection with his long-continued fights against the white plague. In addition to very arduous work, continuing over many years, it is stated that he and Lady Gage have given in the neighborhood of a quarter of a million dollars to help the good cause.

It may be mentioned incidentally that a good many have wondered why John Taylor Fotheringham, M.D., was not included in this new list of knights.

## THE FOOD SUPPLY

Among the latest and most important of Food Controller Hanna's utterances was that given to the public in the New Year. He earnestly urged the people of this country not to lose sight of the needs of soldiers overseas, and also those of the allied peoples. We have an apparent abundance of food in Canada, and that involves a tremendous obligation to our soldiers overseas and to our allies. Upon our stewardship of Canadian food resources may depend in no small degree the ability of our armies to win a passing victory.

In France the crop this year was less than one-half of normal, and a similar story comes from Italy. We have an excellent sample of what saving can do in what has been accomplished by the United States. Under normal circumstances the United States had not a single bushel of wheat to spare for export on December 1st. Conservation measures, however, made it possible to send large quantities of wheat during December to those in need overseas.

We cannot repeat too often what we have learned from Mr. Hanna: the saving of simple, small amounts of wheat, beef, bacon, fats, and sugar, which can be very easily spared without doing us any physical harm, means that tons of food can be saved daily, and every pound of those tons will be needed before next July.

Since this was written we learn that Mr. Hanna has resigned from the Food Controllership. Mr. H. B. Thompson has been appointed new Food Controller. Mr. Thompson is a native of Ireland, but

has been a resident of British Columbia for many years. He was for some time general manager of the firm of Turner, Beaton & Co., wholesale merchants, Victoria. He was elected to the B. C. Legislature in 1907. He has acted the last four months as Assistant Controller, and, like Mr. Hanna, has given his services to the country without remuneration.

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## LANTERN PICTURES OF THE SOLDIERS' RETURN

Sets of lantern slides are now being lent by the Military Hospitals' Commission, free of charge, to ministers and other responsible lecturers throughout the country.

We all have friends facing the risk of wounds that may at any time send them back to us disabled.

What can be done to restore these men to health and to the happiness that comes through self-supporting industry and independence? The answer to these questions is given in the pictures now announced, and in the lectures given to explain them. Full information on the subject, for the lecturer's use, is sent out along with the slides.

As many as thirty-four of these sets, each comprising about 100 slides, are on exhibition this winter. Two sets are being shown by a Caandian Y.M.C.A. representative to our invalided soldiers in England. One set is being exhibited in the United States by the War Work Council of the Y.M.C.A. The rest of the slides are located at important centres throughout Canada. Applications should be sent as follows: Military Hospitals' Commission, Ottawa or Toronto.

# News Items

There is now an epidemic of measles in London, Ontario. There were 107 cases in quarantine on January 4th.

We learn with satisfaction that we are likely to have soon the aeroplane ambulance sailing through the air from the battle-front to the base hospitals.

Two citizens of Toronto were fined in the Police Court January 3rd for allowing their children to attend school from homes where members of the family had contagious diseases.

The new hospital for tubercular soldiers at Byron Sanitarium, London, costing about $200,000, was opened by His Excellency the Governor-General, January 21st.

The patients in the Hospital for Incurables, Toronto, were entertained in a pleasing manner at a "high tea" and oyster supper by Sir Henry Pellatt, January 4th.

Compulsory notification of cases of venereal disease is now demanded in the Province of Saskatchewan, following the Australian plan of reporting the disease without giving the patient's name.

The following officers were re-elected by acclamation as trustees of the schools of Toronto:— Dr. Caroline Brown in Ward 5, Dr. John Noble in Ward 2, and Dr. John Hunter in Ward 6.

The Militia Department of Canada has issued a denial of the statement which appeared in the Press about October 1st, that our forces in France are inadequately supplied with dentists. On the contrary, the Canadian Army Dental Corps overseas, which now consists of 250 officers and 549 non-commissioned officers and men, is a most efficient organization, and has done exceedingly good work in many directions.

# Personals

Fort McHenry, Baltimore, has been converted into a Base Hospital for the army.

Surgeon-General Braisted, U.S. Navy, announces that the health of the men in the navy is good.

General Ashton has to come from England, and is likely to be in Toronto until the spring.

Dr. Lillias Cringan, of Calgary, Alta., visited her old home in Toronto in the New Year.

Major J. S. Boyd, C.A.M.C., is now acting as senior medical officer at Toronto Exhibition Camp.

Dr. C. H. Allen, of Albany, N.Y., was married on Christmas Day to Miss Mary Lynn, of Toronto.

Dr. E. A. Peaker was elected president of the High Park Curling Club, Toronto, January 4th.

Dr. W. G. Hallam went to Northfield January 2nd, to represent Toronto University at the National Y.M.C.A. Association.

Dr. Walter W. Wright has recently gone to France from England, and has charge of the eye work, No. 4 Division, C.E.F.

Major (Dr.) Gilbert Royce, Toronto, C.A.M.C., was appointed Officer Commanding the Canadian Hospital, Bromley, Kent, England.

Major G. L. Keogh, C.A.M.C., of Chatham, has been appointed honorary president of the Great War Veterans' Association.

Capt. Gordon McLarty, M.D., has been awarded the D.S.O. for his bravery while acting as medical officer of a British regiment.

Dr. McCullough, C.O.H. for Ontario, has sent to all the physicians of Ontario literature dealing with the prevention and cure of venereal disease.

We learn with regret that Dr. Thomas McKenty, president-elect of the Canadian Medical Association, will be unable to preside at the meeting in Hamilton.

The following doctors were awarded the Military Cross:—Major Arthur Jones, Capts. H. Allison, C. Fenwick, R. Gardiner, R. Herald, and H. Whytock and Sgt.-Major Ostensand.

We are glad to announce that Dr. H. C. Parsons (Major), who went overseas with the Toronto University unit, has been gazetted Lieut.-Col. He is at present chief of the medical service at Basingstoke Hospital.

Capt. A. F. Laird, formerly of Blenheim, Ontario, joined the R.A.M.C. early in the war. He has already greatly distinguished himself, has been mentioned in dispatches, and has also been awarded the Military Cross.

Dr. Chas. H. Higgins announces that he has resigned as pathologist of the Dominion Department of Agriculture, and in the future will be associated with the Lederle Antitoxine Laboratories, Ottawa, as their Canadian representative.

Capt. Hon. A. J. P. Howard, a son of Dr. Howard, who is married to the daughter of Lord Strathcona who is now Lady Strathcona, and grandson of the late Dr. H. P. Howard, of Montreal, was seriously wounded about January 1st.

Wilfrid T. Grenfell, C.M.G., M.D., Oxford, for a time house surgeon at the London Hospital, who has spent twenty years among the fishermen of Labrador, has built for them four hospitals, one orphanage, besides starting numerous industrial schemes for their benefit. He arrived in Toronto January 25th, and spent more than a week in that city, during which time he delivered many interesting addresses.

We were glad to learn that Capt. Staunton Wishart, C.A.M.C., son of Dr. Wishart, Toronto, was mentioned in dispatches by General Allenby for gallant conduct and dis-

tinguished service while acting with the British forces in Palestine. In a very interesting letter, written November 30th, he speaks of Gaza, Beersheba, Jerusalem and other places in the Holy Land.

We are glad to note the fact that the son of our friend Dr. W. H. Jeffs, of North Yonge Street, has highly distinguished himself in the war, and was presented with the Military Cross by His Honour Sir John Hendrie at Government House, January 5th. Major Jeffs went overseas with No. 10 Field Ambulance in the early part of the war.

We are glad to announce that Dr. Bob Mullen, formerly of Hamilton, who was for some years at Minneapolis, has returned to Canada, and is now in Vancouver, B.C. He is spending half of his time working in the new University of British Columbia, and the other half in the Vancouver Military Hospital, which was opened in September as an annex to the Vancouver General Hospital.

Dr. Hugh A. Stevenson, after being elected Mayor of London for three consecutive years, ran again for a fourth term. At the last election he was defeated. It is stated that Mayor Stevenson in his three years scored two records. The first was made two years ago, when he and his opponent finished a tie, and the issue was decided by the casting vote of the city clerk. The second was last year, when he had the largest majority that was ever known in that city.

Congratulations to Dr. J. M. Salmon, of Simcoe, Ont., aged 94, February 14, 1918! He received his license to practise in 1847—seventy-one years ago. His mental faculties and physical senses are in good condition, excepting his sight which has become defective in recent years, although, even now, he can write a letter which is quite legible and shows little indication of failing strength.

# Obituary

## CHARLES J. KELLY, M.D.

Dr. C. J. Kelly, a well-known physician and X-ray specialist of Toronto, died at Tucson, Arizona, December 29th, 1917.

## ROBERT W. SMITH, M.D.

Dr. R. W. Smith, a graduate of the University of Toronto, who joined the C.A.M.C. in London in 1916, died December 26th, 1917, from what was supposed to be a septic sore throat combined with anæmia.

## HUGH McCOUGHAN, M.D.

Dr. McCoughan, who practised in Thamesford, Ont., for fourteen years, died November 25th, 1917, in Port Arthur, aged 45. He graduated M.D. from the Western University in 1902.

## GEORGE NAPIER THOMAS, M.D.

Dr. Thomas graduated from the University of Toronto in 1904. After practising at Bracebridge he went to North Ontario and settled in Porcupine in 1910. He died in the Toronto General Hospital December 7th, aged 38.

## THEODORE C. JANEWAY, M.D.

We have to announce with deep regret the death of Professor Theodore Janeway, of Baltimore, formerly of New York, which occurred December 15th, 1917. In addition to his vast host of friends in the United States, a large number of the physicians of Canada held him in very high esteem.

## PHILIP JOSEPH MUNGAN, M.D.

Dr. Philip Mungan died at St. Joseph's Hospital, London, Ont., December 7th, after an illness of two months, aged 45. He graduated in 1904 from the University of Toronto, and commenced practice in London in 1906. He was for many years Grand Supervisor Medical Examiner of the Catholic Mutual Benefit Association of Canada.

## F. W. NAEGLE, M.D.

Dr. F. W. Naegle, one of the best known anæsthetists in North America, was found dead in his garage, January 24th, with every evidence that he had been overcome by gasoline fumes. He was a graduate of McGill University, for some time anæsthetist to the Royal Victoria Hospital, Montreal, and last year was elected president of the American Association of Anæsthetists.

## ERNEST ZAVITZ STIRRETT, M.B., R.C.M.

Dr. Stirrett, of Toronto, graduated M.B. University of Toronto in 1915. Before graduating he enlisted and was accepted, and after serving in various places was appointed surgeon of the Patrol Fleet of the Royal Canadian Navy, with headquarters on board the *Niobe* at Halifax. He broke down early in the year 1917, returned to Toronto, and after a somewhat prolonged illness died June 22nd. The remains were buried in Toronto with full naval and military honors.

## STEPHEN BALLARD POLLARD, M.D.

Dr. S. B. Pollard, of 396 College Street, Toronto, died at his residence after a somewhat extended illness, December 28th, 1917, aged 72. Soon after graduating from the University of Toronto in 1869 he commenced practice in Toronto. His success for a number of years was marked, but many years ago ill health prevented him from devoting his full attention to his medical work, and practice fell away materially.

## W. D. YOUNG, M.D.

We have to record with deep regret the death of one of our ablest young physicians of Toronto, Dr. W. D. Young, of 1986 Queen Street East, aged 43, after a short illness from pneumonia. He was born in Ottawa, graduated in Arts from Toronto University in 1897 and in Medicine in 1902. For a time after graduating he had charge of the Department of Chemistry at the Technical School. He soon commenced practice in the eastern part of the city, and his success was almost, if not quite, phenomenal. So far as skill and goodness of heart were concerned he was very much like the late Dr. Cleland, and was much beloved by all his patients, and others who knew him intimately.

## LIEUT. OSLER

Recent reports have given us but little information regarding the particulars surrounding the death of Revere Osler, which occurred in France, August 30th last. His death was caused by wounds of the chest and abdomen inflicted twenty-four hours before, when, with seven other men of his battery, he was at work in the open preparing to remove the guns. A stray shell exploded in their midst, wounding all. At the clearing station to which he was taken he was recognized as his father's son, and Dr. Cushing, of Boston, Dr. Crile, of Cleveland, and Dr. Brewer, of New York, were summoned from nearby American stations, and stayed with him to the last, doing all that skilful and loving hands could do to alleviate his sufferings.

Young Osler was a commoner of Christ Church, Oxford, when the war broke out. He joined the McGill Hospital unit on its arrival in England, and served for eight months with it in France as assist. quartermaster, with the rank of captain, and while thus engaged was much beloved by all who came in contact with him. But at this time we learned from his relatives in Toronto that he was not satisfied, and at his own urgent request he returned to England, where he at once entered the artillery service, in which, as soon as he qualified, he was given a commission.

## THOMAS DAVISON CROTHERS, M.D., HARTFORD, CONN.

Dr. Thomas D. Crothers died at Walnut Lodge Hospital, Hartford, on January 13th, of pneumonia. He was born at West Charlton, N.Y., September 21st, 1842. He began practice in West Galway, but removed to Albany in 1870, where he was appointed assistant professor of the practice of medicine in the Albany Medical College. In 1875 he was appointed assistant physician to the New York Inebriate Asylum at Binghamton. In 1878 he was made superintendent of the Walnut Hill Asylum in Hartford, and when it became the Walnut Lodge Hospital in 1880 he was chosen president and superintendent, and remained there until his death. He was editor of the *Journal of Inebriety* from 1876. For some time he was dean and professor of nervous and mental diseases at the College of Physicians and Surgeons, Boston. Dr. Crothers' specialty was the study and treatment of inebriety and drug addiction, and to this he had devoted his entire professional life.

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Mrs. Reid, widow of Dr. George Reid, Fergus, Ont., died December 31st, 1917, aged 66.

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Mrs. Wylie, widow of the late Dr. Thomas Wylie, died at Burlington Crescent, December 27th, 1917.

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Miss Jessie Kerr, daughter of William Kerr, M.D., of Toronto, died January 2nd.

# Book Reviews

*Progressive Medicine.* A quarterly digest of advances, discoveries and improvements in the medical and surgical sciences. Edited by HOBART AMORY HARE, M.D., Professor of Therapeutics Materia Medica and Diagnosis in the Jefferson Medical College, Philadelphia; assisted by Leighton F. Appleman, M.D., Instructor in Therapeutics, Jefferson Medical College, Philadelphia. Volume IV. December, 1917. Lea and Febiger, Philadelphia and New York.

This concluding volume for the year is exceedingly interesting, in spite of the dearth of original articles in medical literature. Progressive medicine stands alone in its class, a compend of all advances in medical science that are worth recording, and covering every field. The articles in this number are fully equal to any of the previous volumes. No practitioner who wishes to keep abreast of the times can afford to be without it.

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*The Fundus Oculi of Birds, Especially as Viewed by the Ophthalmoscope.* A Study in Comparative Anatomy and Physiology. By CASEY ALBERT WOOD. Illustrated by 145 drawings in the text, also by sixty-one colored paintings prepared for this work, by Arthur W. Head, F.E.S., Chicago. The Lakeside Press. 1917. $15.

For the ophthalmologist who is interested in comparative anatomy, and more especially in the comparative ophthalmoscopic findings, seen on examination of the fundi of birds, the magnificent work of Dr. Wood will fill every need. Only rarely is it our privilege in these days to see a work on which as much care has been bestowed as in this.

As one would imagine the illustrations form a very great part of the work. There are sixty-one colored paintings showing the fundi of birds as well as of some reptiles. These are among the most beautiful illustrations of the subject that we have seen. The black and white illustrations are also very good.

Dr. Wood has gone very carefully into the classifications of the findings, and demonstrates its value for the purpose of classifications and differentiations.

One of his findings that will interest the reader is that domestication or prolonged captivity brings about abnormal changes in the eye ground of birds.

We heartily recommend this work to all ophthalmologists, and to everyone interested in comparative anatomy.

It is a valuable accession to any library.

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### Trench Fever

The etiology of trench fever is still obscure, but there is no doubt that it is of an infective nature. Two clinical types of the disease are distinguished, the one a short fever of about a week's duration, followed frequently after a few days by a short, single relapse, and the other a longer illness characterized specially by the number, sharpness, and periodicity of the relapses. In both forms the onset is sudden, sometimes extremely abrupt. The only constant symptoms are headache, especially behind the eyes, followed soon by pain in the legs (trench shins) and in the small of the back. The incubation period is from six days to twenty-two days. The diagnosis is difficult, and at first the cases were considered to be influenza. Trench fever is to be distinguished from influenza mainly by the character of the temperature chart, but also by the bone pain, which is commonly present in the shins, but occasionally occurs in other bones, and by the general absence of any catarrhal affection of the air passages. There is some reason to suspect that this disease is the sweating sickness of the old writers, which broke out among the armies in Flanders at the beginning of the eighteenth century. There is strong evidence that the disease was imported into the armies at or near Salonica by troops coming from France, and it is thought possible that the infection may reach Great Britain, if it has not done so already.

# Selected Article

## TRENCH NEPHRITIS

*Notes from a Mediterranean Base Hospital.*

By J. C. McWalter, M.D., LL.D., F.R.F.P. and S., Glas.

Trench nephritis has received a very considerable amount of attention since the war began. Full dress debates have taken place upon it at the Royal Society of Medicine and elsewhere.

The trench nephritis hitherto spoken of has been the ordinary Flanders variety acquired in the trenches. Of it, of course, there has been very much less this year than last—and infinitely less trench foot. The type of trench nephritis which falls into our hands here is a Gallipoli or Salonika variety. The ordinary characteristic of it is, that it is really not "trench" nephritis at all—that is to say, cases of nephritis, apparently identical with the disease which one has seen from the trenches of Flanders, and known as "trench nephritis," occur in patients from Salonika, some of whom have never been in trenches. Some of the patients, again, have been, but, as is well known, a trench in Macedonia is a different thing to a trench in Flanders or France.

This leads one to think that the trench is not essentially concerned in the production of the disease, though possibly there has always been the factor of an exhausted, over-heated man, subjected to a sudden chilling of the atmosphere, and in close proximity to newly turned earth.

These men had all been inoculated, both for typhoid and paratyphoid: they had all been recently vaccinated, and a certain proportion had been dosed with anti-cholera, anti-dysentery, and anti-tetanus serum. They lived mostly on frozen meat, and tinned milk, sometimes with some biscuits, sometimes with bread.

The amount of albumin present in the urine in my cases was comparatively small, from two to four parts per thousand. Their appearance was quite good, but the weakness was extreme. Appetite was quite normal, but weight tended to get less. In

some cases blood cells were present in the urine in some cases casts. They were peculiarly liable to become affected by chills or slight variations in temperature. Blood pressure was not high, about 120, but it tended to range higher than in most men of the same age in the ward. Pain in the back is often complained of, vomiting is occasional but not permanent, temperature is usually normal. The patient is slightly bloated in appearance, but has no very marked signs of œdema or dropsy. Headache is usually present, but anæmia is by no means marked. Depression, restlessness, and indifference characterise these patients, although the appetite keeps good. They seldom exhibit much desire to leave the bed, and are usually glad to get back.

The quantity of urine is not notably diminished, the color is pale, or slightly smoky-looking. In about half the cases the albumin was reduced to a mere trace, or disappeared altogether after resting some weeks in bed, and getting milk and a modified Van Noordens diet. Exposure and exercise induce relapse, and hence the patient is of little use for active service after he has contracted the disorder.

One notices in these men a certain mental lethargy, a certain aloofness from the daily life of the ward, or of the tent, a placid indifference to surroundings, a lack of vivacity or vitality, of that exuberance which the sick soldier so often displays. They have a distinct interest in their meals, and eat and drink notably more than a normal ration. In spite of this, there is usually a loss of weight, sometimes equivalent to one pound a week. It is difficult to believe that this wasting can be due merely to the loss of albumin, which would not be more than from a quarter to half an ounce daily.

Those suffering from this trench nephritis seem to be much less subject to malaria than other patients; at least, the incidence of malaria amongst our nephritis cases in this hospital is distinctly less than with ordinary cases. We are accustomed to find malaria intervene in almost every form of disease from the Salonika district, and its apparent absence from those cases is noteworthy.

Few of the patients have been drinkers, in fact, the percentage of consumers of alcohol in hospital patients here is very much less than one meets with in civil practice. They have all been fairly dosed with quinine, but rather less than more than the average patient.

The open-air treatment of nephritis is often lauded, but one finds that patients often get worse after even a few hours in the

open air, even when the day is sunny. They seem to have rather a dislike to the sun. This is a very notable characteristic of most patients from Macedonia; even when free to wander about, they will prefer to be in a dark tent, and will complain of headache if we make them go out for exercise. A certain anaphylactic influence appears to be exercised by the sun's rays on patients who have suffered from any disease associated with high temperature.

Regarding the therapeutics of trench nephritis, one has little to say. If there be a specific, one has neither found nor heard of it. I give urotropine occasionally, and probably do less harm than if I gave it frequently. I give, as routine treatment, tincture of perchloride of iron, with nitrous ether, and solution of acetate of ammonia, and it probably does as much good as anything else. Nux vomica seems to be useful in other cases.—*The Medical Press.*

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**Prevention of Veronal Poisoning**

Hasrud (*Ugeskrift for Laeger*).—Poisoning by veronal may be prevented by prescribing a little powdered ipecacuanha 1½ to 2 grains, with each veronal powder. The dose is too small to be emetic when only one powder is taken, but when half a score powders are taken in an attempt to commit suicide, vomiting ensues and veronal poisoning is prevented. The chances of fatal poisoning may further be reduced by prescribing phenacetin with the veronal, a smaller dose of which is then required to give the same hypnotic effect. Thus:

| | |
|---|---|
| Acid diæthylo-barbiturici ..... | 0.30 gm. |
| Phenacetin ..... ..... | 0.20 gm. |
| Pulv. Ipecacuanhæ ..... | 0.15 |

—*The Medical Review.*

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"What are you carrying a cane for?"
"I'm having a deuce of a time with water on the knee."
"Why don't you try wearing pumps?"—*Puck.*

# Selections

### Use of Radium in Non-Malignant Uterine Haemorrhage

Drs. C. Jeff Miller and E. L. King, New Orleans: The non-malignant conditions of the uterus causing menorrhagia or metrorrhagia may be thus grouped: 1. Cases in which there is little or no demonstrable pathologic change in the uterine wall, no history of infection, and in which the uterus is apparently normal in size and position, with normal adnexa. In such cases the bleeding is, in all probability, due to some disturbance of the internal secretions, especially of the thyroid or of the ovary. This condition is often encountered in young girls about puberty. 2. The menopause. 3. Chronic metritis. 4. Hypertrophy or hyperplasia of the endometrium, especially when so marked as to be adenomatous or polypoid in character. 5. Fibroids, adenomas or adenomyomas of the uterus. 6. Chronic endometritis, especially after incomplete abortion. 7. Passive congestion of the uterus, as in retroflexion or prolapse. In the first three groups, radium may be used to the exclusion of surgery; in the fourth and fifth, some cases are suitable for radium and others require operation; while in the sixth and seventh groups, operation is indicated.

We have treated ten cases classified under the first two groups. In all of them the bleeding had persisted for years and had resisted every form of treatment. Nine of the patients were given intra-uterine radium treatments, the average dose being about 1,000 milligram-hours. In only one patient did the treatment fail to relieve the condition. Only one patient suffered from severe menopausal symptoms, although in several of them the symptoms were present in a mild degree.

Eighteen cases fall in the third and fourth groups. The patients ranged in age from 30 to 55, and most of them had suffered from bleeding for several years—as a rule, menorrhagia first, and later metrorrhagia as well. In every case, radium treatment was followed by amenorrhea; in two patients there was a recurrence of the bleeding about one year later, the flow being approximately normal. The others are still relieved. Six patients suffered from marked menopausal symptoms; five others were similarly affected, but the symptoms were mild and transient. The patients suffering most from

# Encouraging the Nutritive Process

In patients whose digestive and assimilative powers have become so weakened as to respond scarcely at all to food stimuli, it becomes necessary to restore the blood-making organs to their normal efficiency, if a successful issue is to be obtained.

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P.—4

the artificial menopause were nearly all between 40 and 51; this coincides with our experience after hysterectomy. In three women, aged 35, 45 and 51, the condition was relieved by corpus luteum extract. Eight patients suffered from leukorrhea for two or three months after the treatment. In those cases in which subsequent pelvic examinations were made, marked reduction in the size of the uterus was found, and the tenderness, as a rule, disappeared. The dosage in these cases was from 500 to 1,000 milligram-hours.—*J.A.M.A., November, 1917.*

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### Cancer

Research has shown little result during the past year in regard to cancer. Numerous contributions have as usual appeared, but little can be recorded that is new. Bainbridge, in reviewing the situation, says: "(1) So far nothing has been revealed concerning the cause of cancer that need influence treatment of the disease. (2) The various tests and reactions described from time to time have not proved useful for purposes of early diagnosis. (3) Continued investigation has emphasized the importance of co-operation between physician and layman with reference to earlier and more accurate diagnosis. (4) Nothing has been developed which in any sense detracts from the rôle of surgery in the treatment of cancer."

Treatment by radium still gives encouraging results. The report of the London Radium Institute, reviewed in these pages, shows its limitations as regards cancer, although in certain varieties good results are to be expected. W. Douane and R. Greenough report on 642 cases, and claim that in many cases of advanced, inoperable, and recurrent cancer, radium may do good in relieving pain, diminishing discharge, checking hæmorrhage, lessening the growth, and improving the general condition. It is of special value in uterine carcinoma, and in inoperable squamous carcinoma of the tongue, jaw, and buccal mucous membrane, but of little benefit in recurrent or inoperable carcinoma of the breast, stomach, intestine, or glands of the neck. Abbe draws attention to Wickham's method of using radium after operation, where some malignant remnants were left in the wound, and states that he esteems the method very highly, and that there is real hope for this combination of surgery and radium.

The use of colloidal copper, or "cuprase," has had some attention. The communications on the subject, however, show

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—*LANCET*

54

such varying results that little satisfaction can be gleaned from them.

Percy's treatment of cancer of the cervix uteri by means of low heat is shown by F. McCann to be of little use, while the method is liable to produce sepsis.

The effect of tethelin, the growth-controlling principle of the pituitary body, on the development of cancer has suggested a connection between this gland and cancer, with a possibility of its use in treatment of the disease, but so far it is merely a suggestion.—*The Prescriber.*

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### Remedies Useful in Pneumonia

The therapeutic iconoclasts several years ago worked overtime exploiting the opinion that the medical treatment of pneumonia is *nil*. *Med. Standard* (Oct. 1917) believes, however, that most general practitioners attach considerable significance to remedial agencies in this disease. Carbonate of ammonia once so freely and hopefully employed with a view to liquefying the secretions, maintaining fluidity of the blood, etc., had its death-knell sounded by those who did not believe much in drugs. Still we believe that practical and successful physicians use ammonia, ipecac, emetine, apomorphin and many other drugs to advantage in loosening cough, aiding expectoration and, in some measure, facilitating resolution.

The most of us are conservative enough to believe that no single drug exerts a specific role in pneumonia. Quinine in elephantine doses has been encouraged by many doctors as a cure in this disease. The majority of us incline to the belief that the patient's chances of recovery are jeopardized by extreme and prolonged cinchonization. A good many physicians during the past decade have extolled a theory that chloral hydrate to the extent of sustaining a marked somnolency for two or three days will abort pneumonia. It is said that in a case of croupous pneumonia, where the patient does not sleep the first forty-eight hours, the chances of recovery are meagre, and the chloral theory is based on this supposed fact. Again, most of us would prefer to lull the patient into passivity with morphine or codeine rather than resort to a remedy known to be depressant to the heart and vital centres.

Aconite and veratrum are generally recognized as top-line circulatory sedatives during the early febrile stage, but it seems

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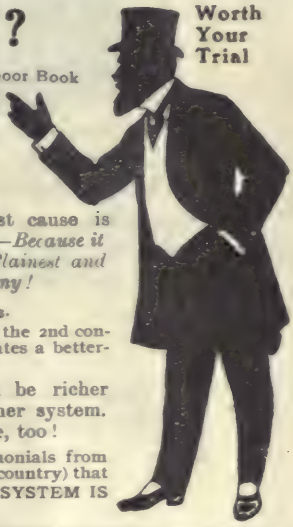

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to be a concensus of opinion that digitalis is about our most useful drug in pneumonia, especially in cases of organic heart disease. Many physicians administer a good tincture digitalis in ten-drop doses three times a day and oftener as the exigencies of the case demand. It is necessary to see that the digitalis is obtained from a source that will insure its potency.

Strychnine is a drug that is often abused, although it is one that has its particular indications. Evidences of toxæmia accompanied by a poor circulation and slow pulse call for this remedy in 1/30 grain doses hypodermically every three or four hours. On the other hand strychnine only whips up the heart in some individuals and makes their lives more uncomfortable, not apparently exerting any salutary effect upon the cardiovascular system.

Camphor as a heart stimulant is one of our most dependable agencies. The camphorated oil may be administered hypodermically in one to three grains as often as stimulation seems required. Caffeine as a stimulant ranks along with camphor and it should not be forgotten that one of the few real indications of whiskey of good quality is at the crisis of pneumonia. The writer has thought that he has seen life saved by the timely and free use of *spiritus frumenti.*

Nitroglycerin is not a true heart stimulant. It may be used to advantage for a short time in cases of cyanosis where the heart is laboring and struggling against high pressure. Oxygen is always of advantage in cases of embarrassed heart and respiration. Abundance of fresh air may usually obviate the need of a tank of oxygen.

Calomel and salines have not been mentioned in this list of drugs, but it is taken for granted that they have been employed in the incipiency of the disease with a view to stimulating secretion and bringing about thorough elimination.—*American Medicine.*

# The Balance of Power in Pneumonia

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# Miscellaneous

## How Do You Treat Pneumonia?

Many months ago, writes Leonard Williams in the *Practitioner* (London), a friend said to me, "How do you treat pneumonia?" Having never completely divested myself of my truculent mid-Victorian training I replied, "With Faith, Hope and Charity. Faith, in the medicatrix naturæ; Hope, for the absence of complications; and Charity with those who differ from me."

"You don't give digitalis?" "No."

"Nor calcium?" "Neither."

"Not even thyroid?" "Animal farceur!"

"And you make no local applications to the chest wall?" "Never."

"Then you are wrong. Listen."

And, being a willing listener, I listened. Some twenty years ago he had seen much hospital work in Paris. At that time in the treatment of pneumonia the practice of many of the French physicians was to blister the affected side, and he had satisfied himself that the cases thus treated did better than those in which the blistering was omitted, and he adopted the practice in England. After a time, however, largely on account of the objections urged by the patients and their friends to the pain and discomfort produced by the blisters, he rather reluctantly ceased to apply them and reverted to the "expectant" method in which he had been nurtured. Time went by, and one day he received an advertisement of a preparation known as Antiphlogistine, for which it was claimed that when applied to the affected side in pneumonia, either lobar or catarrhal, it had the effect of reducing the temperature, slowing the pulse-rate and promoting sleep without any additional treatment. With the memory of his blistering days full upon him, he decided to give it a trial. His experiences were such as to give him encouragement, and to bring him near to believing that not all men, not even all American advertisers, were necessarily liars. . . .

I decided to turn my attention to the claims of Antiphlogistine, which up to that time I confess to having regarded merely in the light of a convenient form of poultice, locally dehydrating, decongestioning and comforting, but probably

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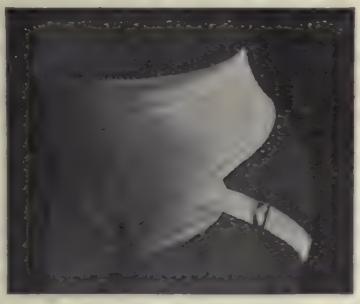

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innocent of any effect upon pulse rates and temperatures. Here again, one case in the history of my conversion must suffice.

In November of last year a young Belgian of twenty years was admitted into the French hospital with a temperature of 104 deg., a quick bounding pulse, slight cough and severe pain in the left side. On admission physical examination was negative. The following day his nose bled, but neither I nor the resident—an experienced Belgian doctor—could detect any signs in the chest. That night he was delirious and coughed a great deal. On the following day he voided some sticky sputum which was typically rusty, and developed labial herpes. Physical examination now revealed the classical dullness and tubular breathing over the lower lobe of the left lung for which I had been looking. His temperature was 105 deg. At about 4 p.m. a gamgee jacket thickly spread with Antiphlogistine was applied over the whole chest. The following morning his temperature was normal.

Now, I do not pretend to explain these happenings; for the benefit of the openminded, I content myself with recording them. The clinician must protect himself against the sneers of the laboratorist. That we are unable to follow the processes by which a healing measure produces its effect is a sorry reason for discarding it. The search for a scientific explanation is a laudable and, academically, an interesting adventure, but in practice it is but a sleeveless errand. Trosseau, probably the greatest clinician of any time, has expressed in characteristically simple words the only position proper for us to adopt: "Je ne vois en therapeutique que deux choses: le medicament applique a l'organisme, et le resultat eloigne de cette application. Quant aux phenomenes intermediares, ils nous echappent, et nous echapperont probablement toujours." Who can explain the process by which digitalis works its wonders; and what advantageth him who can?

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### Nature's Combinations vs. Synthetics

Drugs derived from plants, as nearly in their natural combinations as possible, meet nutritional conditions of the germplasm, which is not the case with synthetics. It would be strange, indeed, if such were not the case, as the latter act upon the system as foreign bodies, depressing and paralyzing the functions or setting up irritation until thrown off or eliminated

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if absorbed. They may have their uses, but are not tonic to neuron-tissue nor molecular upbuilders, as are natural plant drugs. Sanmetto is one of the products from plant elements wrought in the wonderful laboratory of nature, which are assimilable and nourish while they heal, as opposed to the artificial elements wrought in the chemical factories, whose actions upon the human economy are those of foreign bodies, irritating and depressing until thrown off by the conservative and defensive forces of the body.

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### Cholera

Sir L. Rogers, whose saline treatment of cholera has done so much to lessen the ravages of this disease, reports on the use of intravenous sodium bicarbonate injections in post-choleraic uræmia. The most essential cause of this condition is acidosis, the tendency to which is counteracted by the alkali injections. Two solutions are used: (1) sodium chloride, 120 grains; calcium chloride, 4 grains; sterile water, one pint (hypertonic saline; (2) sodium chloride, 60 grains; sodium bicarbonate, 160 grains; sterile water, one pint. Patients admitted early, without prolonged suppression of urine, are given the first solution only, the quantity being regulated by the sp. gr. of the blood. When there has been suppression of urine for over twelve hours a pint of alkaline solution is given with each injection of the hypertonic saline. Details of the method are given, and the author claims to have effected a 70 per cent. reduction in the mortality from this affection. The method was introduced by him in 1915, and was referred to in our pages shortly afterwards.—*The Prescriber.*

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### Hunger in Infants

The material investigated by Taylor included five premature infants weighing from 1,200 to 2,500 gm., forty full term newborns under 3 weeks of age, and eleven older babies, five between 1 and 2 months, two between 3 and 4 months, three between 4 and 6 months, and one boy of 2 years with a surgically induced gastric fistula made necessary by the effects of corrosive in the œsophagus. The gastric movements of some of the infants were recorded only once; on others as many as twenty observations were made. The results of this work fully confirm Carlson

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and Ginsburg's report that the stomach of the new-born infant exhibits greater hunger contraction than does that of the adult. In normally developing breast-fed babies, hunger is not ordinarily an immediate cause of crying. The average time required for the development of hunger in healthy infants gaining in weight and receiving a known sufficient amount of food is, in prematures, under one month, one hour and forty minutes, with a maximum of two hours and twenty minutes and a minimum of forty minutes; in full term infants under 2 weeks two hours and fifty minutes, with a maximum of four hours and a minimum of two hours; in infants from 2 weeks to 4 months, three hours and forty minutes, with a maximum of four hours and thirty-five minutes and a minimum of three hours and twelve minutes. Hunger contractions occur in these infants long before the stomach has emptied. Consequently their presence is not in itself an indication that the stomach is ready for food.—*American Journal Diseases of Children.*

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### The Pneumonia Convalescent

In spite of all of the modern advances in scientific therapy, and the improvements in the general handling and management of acute infectious diseases, acute lobar pneumonia still deserves the title ascribed to it by Osler: "The Captain of the Men of Death." There are, however, especially during the fall and winter months, many cases of the lobular or irregular pneumonia that so often complicates or follows la grippe. When this condition supervenes it is more than likely to follow a subacute or chronic course and convalescence is frequently long delayed. Under such circumstances, in conjunction with treatment designed to hasten resolution, a general blood tonic and vitalizing agent helps materially to shorten the convalescent period. Pepto-Mangan (Gude) is of much value in this field, because it not only increases the solid elements of the blood, but also acts as a true tono-stimulant to the organism generally. As Pepto-Mangan is free from irritant properties and constipating action, it is especially serviceable in the reconstructive treatment of the devitalization following the pneumonia of the aged.

# The Canadian Practitioner and Review

Vol. XLIII. TORONTO, MARCH, 1918 No. 3

## Original Communications

### SOME CLINICAL FORMS OF INFANTILE PARALYSIS

By F. T. Green, M.D., Stoney Creek.

This disease first made its appearance in the municipality of Saltfleet in the year 1910. To my knowledge no case had been reported before that time.

The disease made its appearance, worked its harm, and passed so quickly that its presence or danger was not appreciated at the time, and only the terrible effects of it remained to impress the doctors and public with its gravity. One infant died, three babies were left quite crippled for life, and four others suffered from its effects for years.

There was only one case in the township the past year, 1916. In 1910 the eight cases were in families who permanently reside in the township. The case last year was the child of a laborer, a temporary resident, living in a shack.

The chief industry of the residents is the growing and shipping of fruit, both in the raw and canned state, so that with the help in fruit picking, and a large canning factory, a great many temporary residents come in for the summer months.

The officials of the municipality and land owners are wide awake to the importance of good sanitary conditions, as I have always impressed them with the danger of any serious outbreak of any communicable disease that quarantine might be enforced upon them, which would be disastrous to such quickly perishable products.

I am saying this for the reason that when the disease made its reappearance in the Province last year, the residents were particularly industrious in keeping things generally cleaned up

and fly-proof. Mothers with babies or small children hardly ventured away from their own homes in the months of August and September.

They were advised that they might be carriers themselves of infection to their own children.

This may have resulted in there being only one case last year.

This paper contains a short clinical history of a few cases which were diagnosed as poliomyelitis in the years 1910 and 1916. The prominent clinical symptoms as they appeal to the general practitioner and officer of health will only be touched upon.

*Case 1.* Percy D., aged eleven months, just beginning to walk around a chair.

Two sisters aged eleven and fourteen years; no isolation of patient from rest of family or public.

Healthy baby, breast fed. Family history good. One child died at age of eleven months from broncho-pneumonia after measles. Saw patient first on September 10th, 1910. Slightly feverish, temperature 101; dull and peevish. These symptoms continued for two days, when the temperature dropped to normal and the child was apparently quite well, but the mother discovered that the left leg hung completely helpless, and examination revealed the fact that it was completely paralyzed. The child began to creep again in a few weeks and was in good health and began to hop around again in a few months; by this time the paralyzed leg could be used some in creeping, but hung useless while standing. The mother was untiring in her efforts at rubbing and massage, and he slowly began to recover the use of his limb, and it has grown more than I expected it would. It is one inch and a half shorter; two inches and a half smaller at the calf, and two inches at the thigh, with a condition of talipes-equino-varus, which has gradually been developing. If this foot were straightened by surgical means, it would be a pretty useful leg, as the boy gets around on it pretty well at present.

*Case 2.* Beatrice D., aged two years. Family history fairly good; one child died in infancy. Patient was healthy up till the time it was taken sick—the 24th of August, 1910. No isolation at all; neighbor's children were in and out all the time. The symptoms were much the same as in Case 1—the paralysis coming on almost immediately. The child was fleshy at the time of her attack, and has always been so since, making her

body heavy for her legs. This patient was extra well massaged every day for two years by its mother, and there was little wasting noticed in the size of the leg; but there must have been changes in the muscle and bone, for at present there is a dislocation of the hip joint, the head of the femur often resting on the rim of the acetabulum, it apparently being worn away. This was probably due to the child walking too much in early convalescence. It is almost impossible to keep a child off the diseased leg to its harm. The leg and foot in this case was straightened, and the whole body from the hips down, put in a plaster cast for six months, which resulted in the foot being straightened, but on account of the hip trouble, the operation was not so successful as was hoped for.

*Case 3.* Edward Shaw, aged four years, always healthy, good family history, three other children, aged ten, eight and two years. Saw the patient with Dr. Graham, September 20th, 1916. The child had been sick for two days, and the leg was already paralyzed; temperature 101, with the child very fretful and irritable, any handling or movement seeming to cause pain. Had the other children removed and strict quarantine of the house and both parents for six weeks.

The next day the child was feeling better, but with some retention of urine, but a good purgative relieved that. There was no paralysis of the sphincters. He was kept in bed for two weeks without his clothes, and played and tumbled around on the bed, the leg being dragged and lifted. No reflex response, but tactile sensations were present.

The mother then began rubbing with a hot bath and massage, and in about a month had use of the muscles of the thigh, and hip, and in two months, with the aid of a pair of crutches, put some weight on the leg, and got around a bit, and since that time has gradually improved. He is in good health, walks much better, but should have a brace for the leg and foot, as talipes will likely develop if not prevented.

*Case 4.* Ida B., aged eight years, three other children aged twelve, ten and fourteen years. Family history good. This patient was not strong at the time she was taken sick; was just recovering from an attack of whooping-cough, was always subject to sick stomach. First saw patient September 28th, 1910. No isolation.

She had been feeling ill for some days with weakness of the legs and sickness of the stomach. Parents could not say just what day she was taken sick.

The first day on seeing her she could hardly stand without support, temperature 102, and complained of her legs aching, and extremely irritable, so much so that her parents threatened to punish her.

In two days' time the left leg was completely paralyzed from the hip down and the right one to some extent. The temperature came to normal by October 4th, sixth day, and the pain gradually subsided with the patient feeling better.

By the middle of October, or about twenty days from the onset, she could move the left leg some and the right one quite well and began to creep around on the floor, and being desirous of walking was furnished with a pair of crutches, and in about two months could get around on her feet fairly well, and in four years had quite recovered.

This case was slow in developing, slow in recovery, with very little atrophy.

*Case 5.* Mary S., aged three years, always healthy child. Two other children aged two years. Saw patient September 16th, 1910. No quarantine, complained of pain in the arms for three days, and sick at her stomach, very irritable. Slight fever for four days, temperature 101. Fourth day noticed that the child could not raise the arms to the head, and in two days more could not move the left one at all, and the right one by the shoulder muscles only.

The temperature became normal by the sixth day, and the child appeared quite well except for the irritability. The paralysis gradually disappeared with very little atrophy, and there was complete recovery in about two years. These two cases, four and five, were in the same hamlet, about ten days elapsing between the starting of one case and the other. The symptoms were much the same, developing a little slower, both very irritable and not a great deal of atrophy.

*Case 6.* Sanford B., aged twelve years. Three others, aged ten, seventeen and twenty-four years; good healthy boy.

Was called to see patient September 9th, 1910. Temperature 103, pulse 120, dry tongue, semi-comatose condition.

September 10th, temperature 104, dry baked tongue, quite comatose, no delirium. Catheterized him and gave enæma, urine scant, and small hard movement of bowels. No changes in the urine. Symptoms of uræmic coma or low typhoid condition.

September 11th. Patient much the same; gave large doses of calomel and oil, and the next day—the 12th—the temperature

dropped to 101, bowels moved well, and voided urine, and patient brighter.

September 13th. Patient quite bright, temperature normal but very weak and irritable.

September 14th. Noticed a slurring of speech and difficulty taking fluids into the mouth. Then we noticed that the left side of the mouth was drawn up, and this condition kept growing worse for a couple of days, till it was quite a deformity, which lasted for about four years.

There must have been paralysis of the buccal muscles, and Osler says: "In rare cases of anterior poliomyelitis, the facial muscles of the seventh nerve are affected."

I think this is one of the cases.

*Case 7.* Marshall R., aged twelve years; two others aged fifteen and seventeen. While I was attending the preceding case there was, about two hundred yards distant, a boy sick of what the neighbors told me the attending physician called a type of typhoid fever.

September 20th. I do not know the symptoms exactly, but from what I could learn they were of high fever with condition similar to the case just described, but lasting a few days longer, (ten days), and when the fever left, the patient was unable to walk, and the parents emphasize how very irritable he was for some time after and during the attack.

This patient consulted me about a year later as to advice on his condition, he being lame in left leg, and on examination I found that at the thigh the leg was three inches smaller than the other, and the same at the calf.

I immediately pronounced it a case of atrophy from infantile paralysis, and the doctor who attended him fully agrees with the diagnosis now.

To sum up—We must, if we carry out fully the instructions of the Provincial Board of Health be alert to as prompt a diagnosis as possible.

The two diseases which it might be thought to stimulate are multiple neuritis and Landry's paralysis, but in most cases it can soon be recognized without much doubt. Every case in this municipality diagnosed, has always occurred between the middle of August and 1st of September, and at that time of the year physicians should be watchful for the disease. The presence of any case in the Province should make us doubly alert. I believe that climatic conditions have much to do with the spreading of the disease.

To my knowledge no two cases have appeared in the same family, rather pointing to the source of infection being in some other way than by contact of one child with another. I am inclined to believe that some carrier of either food or drink, flies or human, is the cause. There should be immediate isolation of the patient for safety's sake and also because other children should not be allowed to annoy the patient for a couple of months after. The older the child the less danger there is of permanent paralysis. A child that has never walked will be liable to have permanent disability.

I would advise especially three points in treatment:—

1st. To keep off the paralyzed limb as long and as much as possible, especially if a child. The drawing of certain muscles will cause deformity in bones, and for this reason.

2nd. There should be a suitable brace for the foot and leg.

3rd. And very important, plenty of hot bathing and massage, which the mother could be instructed to give daily, to be kept up for a couple of years.

These three attentions with plenty of fresh air and good healthy conditions, will work wonders in improving the worst of cases.

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## THE OBSTETRIC FORCEPS VERSUS DRUGS

John Hunter, M.B., Toronto.

The attitude of the medical attendant should be influenced by very much the same spirit that inspired the ancient mariners as expressed in the following verse:

> "Oh, where is the shore to which the ship would go?
> Far, far ahead, is all the seamen know.
> Where is the land from which she sailed away?
> Far, far behind, is all they have to say."

All the experience and knowledge acquired since the advent of Cain leave many problems—in legal parlance—*sub judice,* in so far as the management of labor cases is concerned. No one "best method" has been accepted, and as to the value to be

placed on many proposed ones, the diversity of opinion is so great as to fully justify a critic in saying:

"Men's thoughts, and men's opinions
Are tides that ebb and flow,
On ever shifting currents
They are running to and fro."

When Simpson proposed to allay the "pangs of labor" with chloroform, it was assumed the parturient woman had at last reached her "El Dorado." Experience, however, with its stern and indisputable facts, soon taught the obstetrician, that chloroform might imperil the life of both mother and child. Opium, and its derivatives, have been lauded for ages, but here also dire results may follow their use. Hypnotism, prayer, incantations, Christian Science, courage, inspired by physician, nurse, and friends, and the latest, and most acclaimed panacea of all—"twilight sleep"—all to assuage the pains of labor.

It is not the writer's purpose to impugn the teaching or methods of any one, but he does believe that every physician doing obstetric, or any other work, should strive to acquire enough special knowledge and skill to make him as efficient as possible. A man who uses chloroform, morphia, pituitary extract, ergot, morphia and scopolamine, and closely observes the effects of these on mother and child, soon acquires knowledge and skill that inspire confidence. He becomes expert in the use of these, legitimately acquires the rank of a specialist, and gets the results that accrue to highly specialized work.

What has been said is a sort of introduction to the very much debated problem as to any preference for the use of forceps over that of drugs in a large proportion of obstetric cases. Eliminating all those that do not call for any artificial aid, and also all those that demand version, Cæsarean section, destruction of fœtus, or such as are complicated by renal, cardiac, and psychic disturbances, what are the factors in favor of forceps over drugs in all cases that can be delivered by either without imperilling mother or child, or of injuring the maternal structures? The use of drugs calls for a consideration of their purity, dosage, the patient's sensitization toward them, rapidity, intensity, and duration of their action, vascular, cardiac, renal, and psychic conditions—in brief, the use of drugs is always more or less of an experiment. A whole chapter could be written on the surprises and disappointments incident to the use of every drug employed in obstetric practice. One enthusiastic fellow says:

"Oh, I shot a dose of pituitary extract into her and the baby was born in a few minutes." The next one you meet says, "Well, I gave pituitary extract and it didn't do any good, so I had to use forceps." Perchance, if you live in a certain district you may come in contact with a "Medical Society bud" who is dazzled with the results of "twilight sleep" and his three-figure cheques. There is yet another, and the most reputable class, whose judgment challenges attention and who say, "Well, everybody cannot acquire the skill necessary to use forceps safely." This class also call attention to the dangers—from the introduction of infectious material, from injury to the maternal structures, and to the child.

In answer to the first of these objections, would it be any less difficult to acquire this skill than to acquire the ability to make the selection of the proper drug to be used, and to eliminate all the contra-indications to its safe and effective action? You have always complete control of the forceps; can you always control the action of your drugs? In regard to infection, the poorest home can furnish plenty of boiling water and a hot "smoothing iron." You can boil your forceps and gloves, and have the nurse or neighbor run over the sheets, towels, etc., with the hot iron even though it does some scorching. Few germs can stand the heat and weight of a hot iron run over their backs several times. You now have sterile forceps, gloves and clothes, you have, by external palpation, determined the position of the child, and about the stage of labor. Conditions call for artificial aid—forceps or drugs. Your instruments and drugs are in readiness; you put on your gloves and make the one and only vaginal examination to be made during the whole course of labor. You find the only impediment to delivery is want of sufficient force, and this can be obtained with the aid of forceps or of drugs. The writer believes that, in at least eighty per cent. of such cases, preference should be given to the use of forceps.

Any infectious material conveyed by sterile forceps must be acquired in the vagina, and can be carried upward by the examining finger, and by the forward and backward movements of the child's head. Again, in every labor case, there are some lacerations of the mucous membrane in the lower segment of the vagina, so that autoinfection is always possible. It is also an indisputable fact that in hundreds of thousands of cases forceps have been used without the slightest evidence of any infection having followed their use. The mortality tables in regard to the use of forceps include all kinds of conditions—

malpositions, extreme exhaustion, faulty methods. Drugs under such conditions would be either absolutely useless, or they would give a much higher mortality. In reference to injury to the maternal structures, forceps so alter the diameters of the head as to somewhat diminish the pressure, and by making traction in different directions the more vulnerable structures may be relieved. With patience, intelligence, and skill, the head can be delivered with forceps with just as few and as slight injuries as in normal unaided cases. Every practitioner knows that the worst lacerations may occur when least expected. Often this untoward result cannot be accounted for. There may be nothing abnormal in the size of the head, position, or in the character of the pains. In regard to forceps being a dangerous thing in the hands of some men—well, so are the surgeons' knives, the engine, the automobile, the pen, the bible, and anything else. Is the child in any more danger from the use of forceps than from narcotism, or from asphyxiation from tetanus of the uterus, or from violent expulsion?

The writer has never used the pituitary extract, nor can he remember having given a dose of ergot to increase labor pains during the past twenty years. He endeavors to determine the position of the child, and progress of the labor, by an external examination. If there be no contra-indication, in the early stage, a hypodermic of ⅛ to ¼ gr. of morphia may be given. If there be any retardation, a vaginal examination is made, and if delivery can be safely effected by either drugs or forceps, the latter are invariably chosen as the safer, and much more controllable of the two.

"Stand by your own honest convictions with good natural inflexibility, the more so when the cry of voices is against you."

# Editorials

## THE REPORT OF THE COMMISSION

Mr. Justice Hodgins' report on the Medical Profession and Medical Education is a clear, comprehensive, level-headed, able document. We hope the profession of Ontario will have an opportunity of reading it in its entirety, because the summaries which have appeared in the press are incomplete. It could not be otherwise because it is impossible to properly summarize such a document. It is so clean-cut and concise that one might almost as well try to summarize a dictionary. One of the best portions of the report is that which deals with the treatment of returned soldiers. He says the man with joints or muscles stiffened, contracted, or paralyzed comes from the surgeon only partly cured. It is the duty of the medical profession, and of the state, to secure for him, if possible, restored power of motion, on which his life's happiness depends.

He inspected the equipment for various forms of therapy, including physical appliances, in Montreal, Philadelphia, Baltimore, Boston, Davisville Avenue, and the Hart House, Toronto.

The institution of facilities for combined treatment and the effect of incorporation into the system of medical education of practical instruction in their use are the most pressing problems of medical education to-day, and these will be more fully recognized as the inflow of incapacitated soldiers increases. There are especially two requirements. 1. Adequate provision for the daily use of those methods for both returned soldiers and others suffering from

the results of accidents, industrial or otherwise. 2. Fitting up of rooms with proper equipment in the physics departments of the Universities.

He had seen the time table for the proposed course on X-Ray and Physical Therapy in the Toronto University and the General Hospital. He considered that only a step in the right direction, as more extensive equipment and instruction were needed. Under the present conditions systematic physical treatment could be obtained only in a sanatorium or a health resort. The object of a physical clinic is or should be to provide all the necessary elements which make one entity. Disjointed they are insufficient, united they have great value. The several agencies, heat, cold, electricity, radiation, movement, massage, bathing, should be adjusted to the needs of each case. They reinforce and succeed one another in a natural sequence producing a great deal of cumulative effect.

The Commission commends highly the work done at the Ontario Hospital at Orpington, England, and the Canadian Military Hospital at Ramsgate, England, and the Rockwood Hospital, Kingston, Ont., by Capts. E. Ryan and D. A. Clark, C.A.M.C. and others, quoting largely from Dr. Fox, who has written a book on the part taken by the Province of Ontario and the Dominion of Canada in this sort of work.

## OSTEOPATHY.

In 1906 there were 13 osteopaths in Ontario. In 1917 there were 100 to 130, the reports varying as to exact numbers. It is supposed there are now 86 members of the Ontario Osteopathic Association

(probably this includes all or nearly all who have taken regular courses in recognized American schools of osteopathy). Of these 46 graduated from the Osteopathic School at Kirkville, Mo. This College had a three-year course of nine months each up to 1916 when a four-year course was adopted. Of the remaining 40 in this Association, 12 came from Still College, Des Moines, Ia.; 7 from Los Angeles, Cal.; 5 from other schools. This leaves about 16 who have not attended any of the recognized colleges. As we understand the Commissioner, there are in Ontario 70 Osteopaths who have taken three year courses, 16 who have taken courses not recognized by the American Osteopathic Association, and a few others regarding whose training no evidence was given.

The practice of osteopathy has obtained a very considerable vogue in the United States and has received due recognition in 44 States. About all the subjects required in modern medical schools are taught in their colleges. Their National Association has established a Research Institute in Chicago, and publishes a journal devoted to osteopathic interests. Osteopathic Schools are raising their standards, and are now laying stress on microscopy and bacteriological research (also pharmacy and materia medica in some cases) and generally lengthening their courses.

There are no osteopathic schools in Canada. Manipulative treatment is becoming more and more recognized as a valuable agent in the care or alleviation of diseased conditions of the bones and joints, but the regular physician does not use it enough in suitable cases.

Only three of the Provinces of Canada have provided for the admission of osteopathic practice, viz.:

Alberta, Saskatchewan and British Columbia. In Alberta a candidate for a license as an osteopath must have the same preliminary education as an ordinary medical student. In the examination for licenses candidates must pass a regular examination excepting that the examination in surgery is confined to diagnosis, and the conduct of minor operations, and for medicine is substituted the theory and practice of osteopathy. Out of 999 on the Medical Register in 1916, only 11 are osteopaths.

The Commissioner does not advise Ontario to follow the lead of the Western Provinces. He thinks the treating of osteopaths as a separate class in regard to their medical training would be, especially at this juncture, a very great mistake. In addition he doubts the advisability of changing the law so as to allow osteopathic colleges existing outside of Ontario to draw and educate our youth. He is not in favor of harsh treatment of those practising osteopathy in 1913, the year Sir James Whitney announced his intention to appoint a commission to inquire into medical education, and would advise the granting of licenses to the bona fide, properly trained (from an osteopath's standpoint) osteopaths in practice at that time. Such license should not permit its holder to use drugs, perform surgery with instruments, sign death certificates, or use the term Doctor.

### CHIROPRACTIC AND MANOTHERAPY.

There are 25 members in the Ontario Chiropractic Association, most of whom have taken courses of one or two years of six to nine months each. There is one Chiropractic College in Hamilton.

The Commissioner says that he cannot accept a

system which denies the need of diagnosis, and ignores all modern scientific methods. Manotherapy is a name for manipulation by hand which has no distinctive features.

### MEDICAL EDUCATION.

Two of the most important considerations are diagnosis and treatment. The Universities grant degrees, and the Council grants licenses. The students get instruction on technical subjects in the Universities and clinical instruction from the regular school, who see nothing in any cult such as osteopathy, but as to the old cry, "Can any good come out of Nazareth," the Commissioner thinks yes, and asks the profession to give physical therapy its due place in the art of healing.

There are several other interesting and important subjects discussed, some of which we shall refer to in a future issue. In the meantime we give a summary of the remaining portion taken from the Toronto *Mail and Empire.*

#### CHRISTIAN SCIENCE.

In dealing with Christian Science the Commissioner points out that there can be no interference with the right of members of that sect to practise the tenets of their religion, but that since Christian Science treatments had the effect of eliminating the regular practitioner, the interests of public health demanded that such persons should be held responsible for possible mistakes in the nature of the disease.

"They should, therefore," he said "conform to the present or future health regulations, and when they act for gain they should be required to possess sufficient medical knowledge to recognize diseases pronounced by the health authorities to be communicable."

"Their rights," he continued, "should be carefully restricted to the bona-fide exercise of the tenets of their religion, and they should possess no other right or immunity from that enjoyed by the clergyman or minister who is called in for the spiritual benefit of a member of his communion and whose ministrations often react beneficially on physical suffering."

The Commissioner recommends heavy penalties for the Christian Science reader who attends a person suffering from communicable disease without first notifying the health authorities. He strongly advises no moderation in the statutes respecting the treatment of children.

The claim of the optometrists for statutory recognition is sympathetically received. The Commissioner would grant it to those passing a specified examination that would require ability to detect disease through the eyes, a knowledge of the physiology and pathology of the eye and a thorough knowledge of practical optics and refraction. Further educational facilities would also have to be provided.

The report deals at length with the relations between the Medical College and the universities. The Commissioner's conclusion, supported by a great deal of data, is that it would be inadvisable to do away with the present independent examination. He questions the advisability of a joint examination, but would leave it to the universities to say whether they will divide their degree-giving power.

In supporting the proposal for a provincial medical director he points out that as the medical profession has a virtual if inevitable monopoly there should be some provincial authority to whom the public might appeal against evils which such exclusive rights might give rise to.

"Besides the profession requires to be protected against itself," he says, "against sloth and inefficiency in the conduct of its preparations as well as its practice and against inability or unwillingness to receive or try out new ideas or new methods."

The Commissioner deals briefly with homœopathy, pointing out that apparently its followers are dwindling in numbers. He characterizes as "manifestly improper" the fact that three out of five homœopaths on the Medical Council name the colleges where training may be taken whereas the whole Council is responsible in other matters.

The Commissioner endorses the demand for the nurses for recognition, and urges the need for further training facilities. He suggests a new class of nurses, those with lower qualifications than graduate nurses, who can go into a home and take care of the sick under the supervision of a doctor or a registered nurse.

Discussing dentistry the Commissioner recommends that the surplus of the Royal College of Dental Surgeons be turned over to the universities to provide increased facilities for training students.

## AMERICAN DOCTORS IN ENGLAND

The *Literary Digest*, February 2nd, tells us that American physicians are not physicians at all after their feet touch the sacred soil of Britain. They are simply outlaws no matter what their value may be in international medical circles. The *Hospital*, one of England's best medical weeklies, tells us that the first medical contingent from the United States has received a sincere and unrestrained welcome from the British profession. It goes on to say " However, strange as it may seem, these gentlemen are destitute of the technical status necessary to hold medical appointments in this country." The *Hospital* tells us that the status of the visiting Americans is that of unregistered practitioners, and it cannot be altered except by legislation, and legislation on such a subject clearly cannot be arranged before the termination of the war. It will come in time, no doubt, for the principle of accepting by the British diplomas obtained outside of Great Britain has been widely recognized as is shown by the inclusion in the official list of something like 1,000 physicians who have acquired their qualifications at colonial or foreign medical schools.

We have to confess that the *Hospital's* logic puzzles us very much. It gives us to understand that the condition cannot be altered except by legislation, and legislation on such a subject cannot be arranged before the termination of the war. We cannot understand any reason for such a statement because we feel perfectly certain that the legislation required to clear up this absurd position could "be arranged" in about five minutes if the British really wished it.

We are at war and the American nation is fighting shoulder to shoulder with us. Under the circumstances we have a very strong feeling that the medical profession of the United States should be treated decently by the physicians of Great Britain.

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## A CANADIAN MEDICAL WEEK IN HAMILTON

Arrangements for the big Canadian Medical Week have progressed favorably, and we are now in a position to make some announcements regarding the programme.

A personal conference in Ottawa with Surgeon-General Fotheringham of the Militia Department, and representatives of the other agencies interested in the returned soldier problem, resulted in bringing the plans for the symposium on this subject for Wednesday evening to a very satisfactory status.

Prof. Barker, of Baltimore, will give the address in Medicine; Dr. Charles Mayo, Rochester, in Surgery; Dr. Isaac Jones, of Philadelphia, on the Ear. Regarding the work in the sections, the general principle will govern in all, that there will be a very few papers, but it is the expectation of the Committee that each paper presented will promote a very elaborate discussion so that in a sense each will represent a symposium. The writers of the papers are asked to present a synopsis, which will be ready and in the hands of the Committee before March 25th, which will be available for those wishing to prepare anything for discussion.

In the Sections of Medicine, amongst others, the following have agreed to take part: Leonard Rowntree, of Minneapolis; Beatrice Hinkle, of New York; W. Gordon Lyle, of New York; J. Chandler Walker, of Boston, and Thomas McCrae, of Philadelphia. On Eye, Ear, Nose and Throat—Casey Wood, of Chicago; Walter Parker, of Detroit; John Wheeler, of New York; Jos. Beck, of Chicago, and H. Halsted, of Syracuse. In Surgery, McGuire, of Buffalo; Hyman, of St. Louis; Guthrie, of Sayro, Pa., and Henderson, of Rochester, Minn.

It is proposed to have, in addition to the regular programme in sections and general sessions, an innovation in the nature of a round table discussion on a matter of vital importance to the

profession as a whole. Such will be arranged for late in the day when the regular programme is finished. Accommodation for this will be limited and all seats reserved.

Plans are also under way for the presentation of a most interesting collection of scientific exhibits. There will be a pathological exhibit, which will include a very fine collection of museum specimens from the McGill University Museum, which will be in the personal charge of Dr. Maude E. Abbott, of McGill, and also an exhibit from the Babies' Hospital of New York City, of a number of specimens illustrating pneumonia in children. It is hoped also, to obtain similar exhibits of equal interest from the museums of Queens, Toronto, and of the Western. There will be a series of daily demonstrations of clinical laboratory procedures, including those of special interest to the general practitioner, such as the Wassermann reaction, the colloidal gold functional kidney test, dark field for spirochæta, and the preparation of serums and vaccines for therapeutic use.

In the X-ray exhibit, plates are requested to be sent in by men interested in this work. There will be a daily informal demonstration and a lantern will be available for all those wishing to use it.

There will be shown daily from 4 to 6 p.m. moving pictures on medical and surgical subjects, including subjects of interest to the general practitioner.

Definite information regarding many of these items will be available and published in the form of a bulletin for distribution on each day of the meeting.

The American Medical Association have offered the use of their charts, illustration and literature, relating to the propoganda for reform, as carried on by that Association.

The local Committee also wish to announce that it is their wish to carry out the programme and all entertainments with greatest respect for war conditions. While there will be no formal reception or entertainments, this ambitious city will go the limit of their capacity in their efforts to make the visiting members welcome, comfortable and satisfied.

## CANADIAN PUBLIC HEALTH ASSOCIATION

Provisional Programme of combined meeting of the Canadian Public Health Association and Ontario Health Officers' Association, to be held at Hamilton, Medical Week, May 27th to June 1st, 1918:—

Presidential Address, Canadian Public Health Association—"A Plea and a Plan," W. H. Hattie, Halifax, N.S.

Presidential Address, Ontario Health Officers' Association—H. W. Hill, London, Ont.

"The Public Health Nurse"—J. A. Baudouin, Lachine, Que.

Paper (title not received)—M. M. Seymour, Regina, Sask.

"Good Public Health Service in Small Towns and Rural Municipalities"—J. J. Harper, Alliston.

"Hints on Rural Health Administration"—J. W. S. McCullough, Toronto.

"The Control of an Outbreak of Diphtheria"—W. C. Allison, Toronto.

"The Trail of the Medical Vampire"—Frederick Paul.

"Health Insurance"—Charles J. Hastings, Toronto.

"The Venereal Disease Problem"—Gordon Bates, Toronto.

"Why is it Worth While to Establish Sewerage in a Small Town?"—F. A. Dallyn, Toronto.

"Interpretation of Water Analysis"—H. M. Lancaster, Toronto.

"Mental Hygiene"—Clarence M. Hincks, Toronto.

Symposium on Child Welfare.

Chairman's Address—Alan Brown, Toronto.

"Child Welfare in War Time"—Isaac Abt, Chicago.

"Progress in Child Welfare Work in Europe"—Grace L. Meigs, Washington, D.C.

"The Results of Three Years' Work in the Department of Child Hygiene, Toronto"—Geo. Smith, Toronto.

"The Medical Student in His Relation to Infant and Child Welfare Work"—Richard Bolt, Cleveland, Ohio.

"The Management of a Child Welfare Week in Small Cities and Towns with Results"—Mary Power, Toronto.

Round Table Discussion and Subscription Luncheon—Alan Brown, Chairman.

# News Items

The Board of Governors of Western University, London, Ontario, decided for the first time, January 31st, to admit women to the Medical College.

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Several reports have reached Toronto during the last year to the effect that things are not running smoothly and satisfactorily at Orpington Hospital (Ontario), Kent County, England.

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It is reported that the difficulties of transportation across the Atlantic are becoming very serious from month to month. It was stated early in February that there were 20,000 wounded and medically unfit in England waiting for transportation.

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Early in the year various epidemics of smallpox and measles in Ontario were reported. There was rather a serious epidemic of typhoid fever in the City of Hull in January owing, it is said, to a break in the chlorination plant which occurred in December. There were 29 cases in the Hull Hospital, January 9th, and in addition about 100 cases in private houses throughout the city.

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Word was received in Hamilton, February 9th, saying that on the previous day Col. George S. Rennie, C.A.M.C., was invested with the insignia as Companion of the Order of St. Michael and St. George, by His Majesty King George. Dr. Rennie went overseas nearly three years ago with the rank of Lieut.-Colonel. Two years ago he was promoted to full Colonel. He has been acting for some time as O.C. No. 2 Canadian General Hospital, France.

# Personals

Dr. Alfred Caulfield returned from England and reached Toronto, February 11th.

Dr. H. S. McCallum, of London, delivered an address on "The Mind as a Cause and Cure of Disease," before the Women's Canadian Club, Hamilton, February 7th.

Lieut.-Col. C. D. McAlpine, gazetted "Commander of the Order of the British Empire," January 11th, is a son of Dr. J. A. McAlpine, of Lindsay.

Dr. Downham, formerly assistant to Dr. Hill, M.O.H., has been appointed Inspector of Public Health in London, Ont. He has been asked to deal energetically with the present epidemics of communicable diseases in that city.

Lieut.-Col. Graham Chambers is still at Moore Barracks Hospital, England, and we are glad to say that letters received about the middle of February indicate that his health is excellent, better than at any previous time since he went overseas.

Capts. McMillan and Muirhead, C.A.M.C., were still in England when last heard from. Various rumors have reached us during the last year to the effect that they are not well pleased with the situation so far as they are personally concerned. We have never heard why.

Dr. Wilfred T. Grenfell had a serious attack of laryngitis in Toronto, January 31st. Dr. Gibb Wishart, who was called to see him, ordered him to cancel all engagements for lecturing for over one week. We were informed February 11th that he had nearly or was quite recovered.

The name of Dr. Rupert McKibbon, of Victoria, B.C., was recently erased from the Medical Register of his Province. According to the reports received, Dr. McKibbon was convicted in the local police court last October on a charge of wrongfully issuing a prescription for liquor, and was fined $100.

George Clemenceau, the man of the hour in France, is a physician, and the son of a physician. He never was successful in practice, but distinguished himself as a teacher, a writer and a politician. He recently passed his 76th birthday, but is now apparently as strong and vigorous physically and mentally as the average man of 45.

Dr. James S. Sprague, Belleville, Ont., was recently elected an honorary member of the Medico-Legal Society of New York City, of which the late Dr. T. D. Crothers, of Hartford, Conn., was President. Dr. Sprague, in 1917, was also elected an honorary member of the Forensic Medical Society of New York City. Dr. Sprague is one of the oldest contributors to our columns, and to him we extend our congratulations.

Lieut.-Col. H. H. Alger, who went overseas as medical officer of the 80th Battalion, after several months' service in the trenches, has been sent to a base hospital for instruction, and goes from there to England to standardize the Medical Board work, beginning at the base and carrying on the work through England, and thence to Canada.

Dr. Charles J. Hastings, M.O.H., Toronto, was elected President of the American Health Association at the last meeting held in October. This honor was conferred in a very friendly and graceful way, no other name being mentioned for the office. It is not known at present when and where the next meeting will be held. The Executive will probably decide next month. Chicago has been mentioned as the probable place of meeting.

# Correspondence

January 28th, 1918.

*Editor Canadian Practitioner and Review:*

Dear Sir—I shall report to you an unusual case which I had recently, and will be pleased to have you publish it in The Canadian Practitioner and Review if you deem it interesting enough, with any comment on the frequency of such cases, etc.

Patient, Mrs. W., aged 69, farmer's wife, always had been healthy, had never had heart trouble or even indigestion enough to require treatment.

Retired early, feeling as well as usual, not having worked hard during the day. Awoke about 10 o'clock p.m. with severe pain under lower part of sternum.

I was called up at 2.30 a.m. Family told me she had acute indigestion, so I prescribed an emetic and hot applications to epigastrium and sips of hot soda water, etc. Was called again at 4.30 a.m.; patient no better. I arrived at her home about 5.30 a.m.; patient sat up in bed, leaning forward against her knees, moaning with pain. Asked for drinks of cold water frequently, but would retch and vomit soon afterwards.

Examination—No soreness or pain in epigastrium or lower abdomen; lungs clear; pulse 110, irregular but fairly strong; very restless; pain beneath the lower part of sternum.

I gave nearly a whole H.M.C. per hypo. She quieted down some and could lie down. The pulse became regular and fairly strong. After about one hour I went home. She died at 2.30 p.m. that day.

I made a provisional diagnosis of ruptured aneurism. I insisted on a post-mortem examination, which I obtained.

Lungs normal. Pericardial sac distended, on opening of which, perhaps eight ounces of bloody fluid ran out. Also lifted out several large clots. Heart was about size of 14-year-old boy's fist. No aneurism present. On the anterior surface of heart (right ventricle) I noted dark bloody fluid oozing, and found a small opening, which I enlarged with my little finger, then with index finger. The muscle was practically gone and tissue was thin at this point and quite friable.

(Signed)

A. L. Wellman, *Springbrook.*

# Obituary

## CAPTAIN J. F. PALLING, M.D.

Dr. J. F. Palling, Medical Officer 177th Battalion, died in England on February 1st, probably from cerebral embolism or thrombosis, aged 56 years. He graduated M.D. from Trinity University in 1888, and after graduating practised several years in Barrie, at the same time taking a very active interest in politics on the Conservative side. During the last few years he was acting as County Registrar. He was well known and very popular in Barrie and the outlying districts.

## AUSTIN OGDEN, M.D.

Word was received in Sarnia that Dr. Austin Ogden, of that city, had been killed in France, January 16th. Dr. Ogden graduated from Ann Arbor, and was doing post-graduate work in Germany when the war broke out. After being detained for some time in that country he was released and returned to England, where he soon enlisted in a British regiment and crossed to France.

## GEORGE VILLINEAUVE, M.D.

Dr. Villineauve, of Montreal, Medical Superintendent of the St. Jean de Dieu Asylum, died January 21st. He was for many years well known as an alienist. He also took interest in military matters, and served with the 66th Regiment in the Riel Rebellion.

## JOHN H. RITZ, B.A., M.B.

Major John Ritz, C.A.M.C., died in Ottawa, February 11th, after an illness of six months, aged 48. He graduated B.A. in '92 and M.B. in '95 (Toronto) and practised for many years in Elmira. Over a year ago he was appointed a member of the Munitions Board at Ottawa.

## LIEUT.-COL. MACRAE, M.D., C.A.M.C.

The public and profession were shocked and grieved beyond expression to learn, January 29th, that Lieut-Col. John Macrae was dead. On that day Colonel and Mrs. Macrae (father and mother) received a cable message at their home in Guelph, stating that their son John had died January 28th, from pneumonia, at Boulogne, France. He was born in Guelph, in November, 1872. After receiving his preliminary education he went to Toronto and took the double course in the University of Toronto, graduating B.A. and M.B. in 1898. He then spent a year as interne, in the Toronto General Hospital. In 1899 and 1900 he served as Lieutenant in the South African Field Force in the Boer War, and saw much active service. During that war he received the Queen's medal and three clasps. After spending some further time in post-graduate study, particularly at Johns Hopkins, Baltimore, he went to Montreal, and was in every way highly successful in that city. He was for some time lecturer in Medicine at McGill University, Assistant Physician to the Royal Victoria Hospital, and was co-author with Dr. Adami of a text-book on Pathology.

In his youth Jack Macrae was a bright, cheery, manly boy. In later years he grew large, and became a giant even among big men; but with all his magnificent gifts, his wonderful personality, and his extraordinary versatility, he still remained the dear, charming, genial Jack whom every one loved.

The Toronto *Globe* published "In Flanders Fields" January 30th, and added: "On Flanders Fields, or somewhere in France, young Canada will one day visit the resting places of the men who fought and died where between the crosses they lay down: 'As a man might be laying down his book, and knowing a fair tale has been well told.'"

## IN FLANDERS FIELDS

This wonderful poem has been variously described: Jack Macrae's "immortal poem"; "An inspiring and beautiful poem"; "The most outstanding war poem written in the present struggle"; "A poem without a peer in the literature of the great war."

In Flanders fields the poppies blow
Between the crosses, row on row,
That mark our place, and in the sky,
The larks, still bravely singing, fly,
Scarce heard amid the guns below.

We are the dead; short days ago
We lived, felt dawn, saw sunset glow,
Loved and were loved, and now we lie
In Flanders fields.

Take up our quarrel with the foe!
To you from failing hands we throw
The torch; be yours to hold it high!
If ye break faith with us who die
We shall not sleep, though poppies grow
In Flanders fields.

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The following is a portion of a poem which appeared in the Toronto *Mail and Empire,* February 7th, 1918:

### REQUIESCAT IN PACE JOHN MACRAE

Ah! soldier poet, thy words are few,
But for thy song we give thee gage anew,
And hold it high where lilies wave
In stately whiteness o'er thy grave,
To carry on, till, victors, we may view
Our Flanders field.

And that thy death-song be not vain,
With straining hands we grasp the torch again,
And hurl it on to flame and flash
Amid the shell's wild scream and crash,
To live or die through mists of pain
At Flanders field.

Peace to thy ashes, John Macrae!
Dost hear our legions pressing day on day?
So they may sleep where poppies blow
Between the crosses, row on row,
Till morning breaks and shadows flee away
From Flanders field.

—Emily C. Dempsey.

Hamilton, February, 1918.

# Selected Article

## THE TREATMENT OF HAEMOPTYSIS

By P. Bergman.

The methods of arresting hæmorrhage from a tuberculous lung may be classified according as they act by modifying the circulation of blood through the lungs or by hastening coagulation. In the first class four principles may be considered—prevention of rises of pressure in the pulmonary arteries, lowering of the pressure in these arteries, contraction and compression of the bleeding vessel.

To prevent rises of pressure in the pulmonary arteries, the patient is kept at rest and semi-recumbent, in which position expectoration is effected most easily. It is not advisable to maintain absolute rest, which soon becomes irksome, for slight movements can have no appreciable effect on the pressure in the pulmonary circulation. This is almost completely independent of the pressure in the systemic circulation. Experiments on animals have shown that, by various means, the pressure in the aorta may be greatly raised without affecting the pressure in the pulmonary circulation. Only after obstruction to the flow of blood through the left heart is the pressure in the pulmonary circulation raised. It is, therefore, extremely improbable that slight movements sufficient to raise the pressure in the systemic circulation can have any effect on the pressure in the pulmonary vessels. These have no vaso-motor nerves, and the pressure within them is regulated by quite different factors from those governing the pressure in the systemic circulation. Coughing, on the other hand, should be checked, as it undoubtedly raises the blood pressure in the lungs. The patient is urged to cough as gently as possible, but suppression of sputum and retention of effused blood is apt to follow the prescription of morphine for the cough. Codein should, therefore, be given instead, as it relieves cough without effecting that stagnation of the secretions induced by morphine. The pharmacodynamic characteristics of the bronchial muscles, it should be remembered, are those of the intestine; and only in exceptional cases, and then only with great care, should mor-

phine be given. Its constipating action is a further contra-indication.

With a view to preventing rises of pressure in the pulmonary circulation, attempts have been made to limit the excursions of the lungs by keeping the patient lying on one side, by surrounding him with sandbags, and by strapping his chest. It is, however, often so difficult to determine from which lung the hæmorrhage arises that the physician is in doubt as to which side to strap. In the absence of sensory nerves to the lungs the patient's sensations in this respect are unreliable; and râles may be misleading, as they may be due to blood aspirated into the lung which is not bleeding. Even if the exact site of the hæmorrhage were known, these measures would be practically valueless, for the variations in the pulmonary blood pressure caused by the respiratory movements are slight. Only the sudden rises of pressure provoked by violent expiration, as in coughing, need be considered.

To lower the pressure in the pulmonary arteries, both mechanical and chemical agents have been tried. Venesection is an example of the first, but it has rightly been abandoned. Another mechanical device is constriction of the limbs with tourniquets with the object of cutting off a large quantity of blood from the general circulation and thus reducing the blood pressure. It is, however, very doubtful whether this measure reduces the pressure even in the systemic circulation; the automatic maintenance of the blood pressure is probably too stable to be thus upset to an appreciable degree. Certainly, a fall of the pressure in the pulmonary circulation has not been experimentally demonstrated as a sequel to this manœuvre. Some writers, ignorant of the lack of vaso-motor nerves in the lungs, have argued that this constriction arrests hæmoptysis by some reflex action, and have on this assumption recommended ligature of only one finger or application of a cold compress to the scrotum. Another objection to constriction of the limbs is the severe pain it causes after a little time; as a method capable of arresting hæmoptysis its value is extremely doubtful.

The drugs still much used on the assumption that they reduce the pressure in the pulmonary arteries are nitroglycerine and amyl nitrite. They certainly reduce the pressure in the systemic circulation very effectively, but they have no effect on the pressure in the pulmonary circulation, and they are, therefore, quite useless. Mellin has shown that drugs of this

class may reduce the pressure in the aorta of a rabbit from ninety to thirty mm. of mercury without affecting the pressure in the pulmonary artery. For the same reason, mustard plasters applied to the skin, diuretics and aperients are valueless. Nauseants are even dangerous, as vomiting is apt to increase the blood supply to the right heart and thus raise the pressure in the pulmonary arteries.

Various devices have been tried with a view to constricting the bleeding vessel in the lung. An ice bag is a favorite remedy, but owing to ignorance, as a rule, of the site of the hæmorrhage, the area where the bag is placed is selected at random. But even if the bag were placed exactly over the bleeding spot, the benefits would be doubtful, for though the primary effect of cold on a blood vessel is contraction, this soon yields to dilation. Ice bags may, therefore, do more harm than good. Ice sucked, and cold drinks may, however, be beneficial by reducing the sensitiveness of the mucous membranes and thus diminishing cough. Of the other remedies supposed to constrict blood vessels none is of practical value, for with constriction of the blood vessels goes a rise of blood pressure. Adrenalin, for example, is contra-indicated because, injected into a vein, it induces great vaso-constriction in the systemic circulation, with the result that the lungs are flushed with blood. Given thus in large doses adrenalin induces fatal œdema of the lungs. Given subcutaneously or by the mouth, adrenalin fails entirely to affect the blood pressure. Ergot, again, is contra-indicated because, as shown by Mellin, it increases the pressure in the pulmonary more than in the systemic circulation. Acetate of lead is also useless. Of the digitalis group, digitalin increases the pressure in the pulmonary circulation considerably and is, therefore, contra-indicated. This effect does not follow the administration of the infusion of digitalis or of the tincture of strophanthus, either of which may be given in hæmoptysis if the lungs are congested with blood and the left heart is diseased. Recently, collapse of a lung by induction of pneumothorax has been advocated as a last resort. This measure is inevitably limited to a very few cases. The operator must know from which lung the blood is coming, and the lung must be unadherent to the chest wall.

More hopeful is the principle of increasing the rate of coagulation of the blood. For this purpose a host of drugs has been recommended. As a mere curiosity, inhalation of a solution of perchloride of iron may be mentioned. The same drug given by the mouth is also useless. Turpentine, given by the

mouth, has been loudly praised, but the writer can find no exact experiments to authorize this belief in the hæmostatic action of turpentine. Gelatine and horse serum certainly hasten coagulation when injected, but they may provoke dangerous complications, such as anaphylaxis, tetanus, and exanthemata. Particularly in febrile cases are these remedies considered dangerous in many quarters. Another shortcoming of gelatine is the slowness with which it acts. Only two to four hours after its administration does the blood begin to show an increased rate of coagulation, which attains its maximum after ten to twelve hours. The changes in the coagulability of the blood are inconstant, but as a rule the rate of coagulation is reduced from four and one-half to one and one-half minutes. The part played by calcium salts in the coagulation of blood has naturally led to their being tested as hæmostatics, but the results are unconvincing.

Sodium chloride, dry or in solution, has long been a household remedy for hæmoptysis. This treatment, as shown by von den Veldon's investigations, is perfectly rational. Within a few minutes of the administration of only five grams, the rate of coagulation is much reduced, remaining so for one to one and one-half hours. Sodium bromide has the same effect and can be substituted for sodium chloride in nervous cases. Unfortunately, many patients find it difficult to swallow large doses of sodium chloride, which are apt to provoke anorexia, vomiting, diarrhœa and even albuminuria. This difficulty can be overcome by injecting the salt in hypertonic solution into a vein. The dose recommended by von den Veldon is three to five c.c. of a ten per cent. solution. Investigations on animals and man have shown that within a couple of minutes of an injection the rate of coagulation is much increased, the effect being greater than when the salt is given by the mouth. After about one hour this effect of the injection passes off. No complications of this treatment have been observed, apart from pain at the site of injection when some of the solution escaped into the tissues about the vein. Though this pain can be severe, it is relieved by hot compresses. In thirty-five out of fifty cases treated by Müller the injection was instantly followed by cessation of the hæmoptysis, and only in five did the treatment fail altogether. Its effect was better in fibrous than in ulcerative pulmonary tuberculosis. The writer has tested it in ten cases of severe or recurrent hæmoptysis with good effect. In most cases the hæmorrhage not only ceased instantly, but did not recur. He recommends this treatment warmly as being both sound in theory and reliable in practice.—*The Medical Review.*

# Selections

## Surgery in 1918

The unsolved problems in surgery multiply as surgery goes forward: if it may be said that on many points surgery is in a state of flux, this is only a sign of progress. It is, of course, especially in matters connected with the surgery of war that the unsettled problems are just now prominent, for much that has been done within the last three years reveals how much there still remains to do. Those who saw many cases of tetanus in the earlier stages of the war will acknowledge that the disease has now lost much of its terror; for if prophylactic doses of the serum be given to all the wounded the chance of the occurrence of tetanus is very slight indeed. An extended experience of its use has led to an increase both in the amount of anti-toxin injected and in the number of doses. Yet even with the present extensive use of tetanus anti-toxin the disease does appear, though generally in a modified and localized form, its severity greatly reduced, and its prognosis vastly improved. Prevention has got ahead of cure, for the treatment of tetanus after it has made its appearance remains unsatisfactory; there is no doubt that the serum has some effect, but, alas, this effect is small when prevention has not been secured. We may not unreasonably hope that in the coming year some advance in the treatment of developed tetanus may be found during further investigation of the best mode of procedure in the management of septic wounds. For this is still unsettled. The claimants are many, and we have on previous occasions reviewed them and compared certain of them. The saline treatment of Sir Almroth Wright, the hypochlorite irrigation of Professor Carrel, the "Bipp" of Professor Rutherford Morison, and flavine and its allies are all of value; each has good qualities, sometimes peculiar to itself and sometimes shared with another method, but each has its shortcomings, each has its successes and each has its failures, and it cannot be said that any of them can be regarded as an ideal method of dealing with septic wounds. In which direction we are to look for the perfect treatment, time will decide; it may well be that some antiseptic will be found the actual virtues of which will surpass any of the claims now made; it may be that some serum or vaccine may be discovered which

will immediately put an end to all or many forms of septic infection; or perhaps in some way the bactericidal properties of the solids and liquids of the body will be so enhanced that the invading organisms will be repelled without an effort. It will, unfortunately, not be for any want of material for investigation that progress in this matter may be slow; many cases must reach the base hospitals, and even the casualty clearing stations, with very septic wounds.

Another condition in which the treatment does not yet fulfil our hopes is that produced by great loss of blood. When the tissues are rent and torn widely with one of the many projectiles which modern warfare has provided, extensive lesions of blood vessels must occur, and if surgical assistance is not forthcoming within a very brief time the loss of blood must be very great, and may of itself or in conjunction with other injuries lead to a fatal issue. To deal with these great losses of blood adequately is by no means easy. It is true that when the loss has not been very great the expedients in ordinary use may suffice—the limbs may be bandaged firmly to drive the blood from them into the trunk and head, subcutaneous or intravenous injections of saline solution may be made, and substances which contract the peripheral vessels may be given, and in that manner the blood pressure can be raised; but these and similar measures are of avail only if the loss of blood has not been excessive. When the hæmorrhage has been very great, saline solution will not suffice to replace the lost blood: so far as we know, nothing but the addition of blood can then make up for the loss of blood. But transfusion has its difficulties. The first is to find someone to supply the blood, and the second is to transmit the blood from the donor to the recipient without allowing any coagulation; but the reference is not to these obvious matters, though they are of great significance in emergency surgery. Allowing that these two difficulties have been overcome, there is a risk, of which serious account must be taken, of the occurrence of agglutination or of hæmolysis. For the blood of the donor may prove to be incompatible with the blood of the recipient, and the resulting hæmolysis prove harmful, if not fatal. It is true that, if time be given, it is possible to test the blood of the donor for isoagglutinins, and this may well be done when the transfusion is for the treatment of pernicious anæmia; but when the anæmia results from loss of blood due to the wound of a vessel, while

treatment must be immediate, some safe method of transfusion is required. Possibly means may be found for preserving blood for long periods, so that it may be available at any time, or some solution may be devised which will replace blood much more effectively than does normal saline solution. Here is a direction in which there is an urgent need for progress.

Of late years good work has been done in the transplantation of organs and limbs in the lower animals; this has been rendered possible by careful suturing of the blood vessels of the parts. A certain measure of success has been attained, inasmuch as clotting of the blood in the vessels has not occurred and the transplanted portion has not necrosed; yet even in the case of transplantation of a kidney in a rabbit the functional activity of the transplanted organ has been extremely small. It is by no means incredible that further experience of these procedures, with modifications which experience points out, will give better results, so that it may become feasible to replace a lost foot or hand with one taken from a limb removed for injury. Imagination suggests many possible applications of such an operation, but how many of these will prove possible and when they will be performed none can tell. But progress in surgery in the year now just begun is certain. There will be no interruption of that steady improvement to which we are becoming ever more accustomed. And it is in this way that discoveries are made. The need for them is in the air; in many centres thinkers of varying equipment, moods, and ideals, concentrate upon this need; the need is met. —*The Lancet.*

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### The Conquest of Gas Bacillus Infections

As anyone, even superficially, acquainted with the medical problems that have arisen in this war, knows, one of the most serious is that of infection by gas-producing bacilli. The long cultivated, fertile soil of northern France is rich with these bacteria; and the war literature bears abundant testimony to the desperate efforts of both French and English surgeons to combat these terrible infections. Thus far their efforts have been anything but satisfactory. Up to last year it was believed that all these infections were due to the gas bacillus described by Welch in 1891. Recently, however, a number of English and French observers have found that only about two-thirds of these

infections were due to the bacillus Welchii, while the remainder are due to the bacillus of malignant œdema of Pasteur and the bacillus œdematients. Sometimes two or more of these bacteria are present in the same wound.

Thus far the only methods that have been available to oppose these infections have been mutilating surgery and the widespread use of powerful antiseptics. Many surgeons, in their desperation, advocate early amputation, recalling to us, in poverty of resource, the old pre-antiseptic days, when the amputation was considered the method of choice in compound fractures.

It seems strange that although we have been acquainted with the cultural characteristics of the bacillus Welchii for over a quarter of a century, no attempt had been made to study its biological or immunological properties. It is another striking instance of the driving power of stern necessity that the solution of this hitherto neglected problem should bear promise and that we shall soon witness the control of this dreaded infection. Up to the time of the work of Bull and Pritchett, in the early part of this year, there were a number of theories as to the destructive power of the bacillus Welchii. Some observers believed that an acid product was formed, others held that there was a mechanical action due to the formation of a gas, while still others regarded the gangrenous condition as due to the pathologic actions of other organisms and that the Welch bacillus developed only after such conditions had been established.

Bull and Pritchett showed, however, that the solution of this mystery was extremely simple. They found that the bacillus caused a specific bacterial toxin, like diphtheria and tetanus bacilli and the bacillus botulinus. In other words, a toxin was produced that was entirely separable from the bodies of the bacteria themselves, i.e., an exotoxin, as opposed to an endotoxin. Now it is an oft-demonstrated truth in bacteriology that when a bacterium is found to produce an exotoxin, that an efficient antitoxin can be readily elaborated. This, Bull and Pritchett demonstrated to their entire satisfaction in regard to the bacillus of Welch. By immunizing animals with bacteria-free toxin, an immune serum was obtained which has the power to neutralize the toxin both in vivo and in vitro. By numerous animal experiments these authors have shown that a prophylactic intravenous dose of antitoxin uniformly confers complete immunity for a period of at least two weeks against many times the lethal dose of toxin. Furthermore, they have shown the antitoxin also

confers an active immunity; thus, if animals are injected with a virulent strain of the organism and the antitoxin is injected twenty-four hours later, the animal will recover. The authors have apparently not yet determined how long after the infection the serum will prove curative. Bull and Pritchett have also discovered that all the different strains of the bacillus Welchii produce the same toxin, so that we shall not be confronted with the problem that meets us with the pneumococcus, for example.

Thus far few observations have been made in human beings, but these have already shown satisfactory results.

We should not be surprised, therefore, that one of the routine procedures for wounded soldiers at the front will be an injection of the Welch bacillus antitoxin, in addition to the injection of the tetanus antitoxin. If this dread infection becomes stamped out, we shall again be able to speak of one of the glories of American medicine.—*E. M., American Journal of Surgery.*

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**Poisoning by Rhubarb Leaves**

Maillart (*Rev. Med. de la Suisse Romande*).—On May 5, 1915, a man, aged 41 years, his wife, servants and four children, aged 8 to 13 years, were attacked by severe diarrhœa some hours after eating a dish composed of spinach and rhubarb leaves mashed together. All the members of the family except the man recovered rapidly. Although the diarrhœa ceased, he continued to feel a sense of weight in the stomach with somnolence and fatigue. There was no headache and the appetite was normal, and the bowels acted regularly.

When first seen on May 13 he appeared to be in good health, and examination revealed only slight tenderness about the pylorus. The urine, which was clear but slightly colored, gave a copious deposit, with Esbach's reagent, which finally showed 2 3-4 per cent. of albumin. He was ordered milk diet. Two days later an analysis by a chemist gave the amount of albumin as 3 3-4 per cent. On May 17 the somnolence and weight in the stomach had disappeared and the pylorus was no longer tender. The albuminuria had diminished to 1 1-2 per cent. There was nothing in the history or physical examination to account for the albuminuria, which had the character of a recent epithelial nephritis. The

milk was replaced by a salt-free diet. On May 25 the amount of albumin had fallen to .17 per cent., and the urinary deposit showed some granular casts, leucocytes and crystals of uric acid. A final examination on May 31 showed that albumin was absent.

The writer was doubtful how far these symptoms could be attributed to the ingestion of rhubarb leaves till he read of two fatal cases attributed to the same cause. One, the child of a Swiss pastor, died, although the other members of the family experienced only passing discomfort. The other case was that of an English clergyman and was also fatal (*Lancet*, June 2, p. 847). These facts suggested that there was some toxic substance present in the leaves of rhubarb, although absent from the root or stem, which was capable of causing acute gastro-intestinal symptoms and also more or less severe nephritis. He was not inclined to regard this toxic substance as oxalic acid or soluble oxalates, owing to the absence of cardiac symptoms in his case. The English case was attributed to oxalic acid poisoning, and rhubarb leaves from the same garden as those eaten by the deceased were shown to contain 1 1-2 per cent. of potassium oxalate, which is soluble and toxic, as well as 1 1-2 per cent. of the insoluble oxalate of lime.

The public should be warned as to the danger of rhubarb leaves eaten as a vegetable, but the danger would be lessened if they were boiled in water with a small piece of lime, and never carbonate or bicarbonate of soda. The liquid in which the leaves have been boiled is dangerous and should be strained off.—*The Medical Review.*

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### The Treatment to be Applied During Convalescence

Doctor Bresard, late Physician to the Tenon Hospital, Paris: Convalescence has been called "the intermediary state between disease, which no longer exists, and health which has not yet been restored." The rôle of the physician is to help nature in its work of recovery, to remove the last traces of morbid disorder, and to prevent, as far as it is possible, relapses.

Convalescence is characterized by debility, lassitude, anæmia, emaciation, and fatigue, on the slightest effort. There is an impressionable condition of the nervous system, and muscular atony.

An excellent tonic to prescribe is globeol, six to eight pills a day. This drug is a total extract of blood with colloidal iron and manganese. Professor Remoud (of Toulouse) has shown that it furnishes the blood with the necessary materials and acts as a tonic of the nervous and muscular systems, without disturbing the digestive organs.

When there are palpitations, tachycardia, and a rapid and irregular pulse, the following mixture may be used:

Fluid extract of socrategus, fl. dr. v.; fluid extract of convallaria, fl. dr. ii. ss.; fluid extract of anonis verdalis, fl. dr. i.; 15 drops three times a day.

In case of vertigo, dizziness, tendency to syncope, due to tympanitis from indigestion, the preparations of nux vomica, ignatia amara, calabar bean and a combination of charcoal and chalk.

It is important to examine the stools microscopically during convalescence after enteric and most intestinal infections.

In case of constipation jubol will give good results, and if there should be mucous colitis, lactic acid bacilli in the form of sinaherase are indicated. When the skin remains dry after desquamation, alkaline baths will do good.

Alopecia is frequent during convalescence. The following will be found a good remedy:

Tincture of arnica, tincture of quillaia āā fl. oz. ii.; tincture of capsicum, tincture of jaborandi āā fl. oz. i. ss.; liquid paraffin, dr. ii. ss.; oil of cinnamon, dr. i.

The scalp is to be well rubbed with the above morning and evening. This is not only a good treatment for alopecia, but often cures headache, which frequently is troublesome during convalescence, and which is nearly always of epicranial origin. Air and light in profusion, regular and moderate exercise, are important points during convalescence.

Against emaciation and loss of strength the best thing is careful and well-ordered alimentary hygiene.

Food should be nourishing under a small volume. Thick milk soups, puddings, with milk and cereals, eggs, light fish, well cooked light meats, mashed or boiled potatoes, cooked fruit, custards, cream cheese, stale bread toasted. Beer, or good red Bordeaux wine, in small quantity.

It is well to make four meals a day, at regular intervals of time.

In a few exceptional cases the appetite is so increased that digestive trouble may arise (malaise, flatulence, etc.), and it

may be useful to give small doses of belladonna or cannabis. If there is gastric atony, hot compresses applied to the abdomen do good.

If there is loss of appetite, prescribe the various preparations of quassia, gentian, calumba, etc., with light alkalines. Cold broth or beef tea, taken about half an hour before meals, act as a mild gastric stimulant.—*Medical Press and Circular.*

---

### Treatment of Anorectal Varices in Pregnancy

F. Martinez Suarez (*Revista de Medicina y Cirugia Practicas,* February 14, 1917) divides the treatment into hygienic and curative. As to prophylaxis he advises the taking of olive oil before each meal and the use of medicated toilet paper after defæcaton followed by gentle washing with warm water and absorbent cotton. Too long walks must be avoided and when sitting the patient must try to rest the weight on one buttock rather than on both. If there is prolapse of the hæmorrhoidal masses at defæcation they should be bathed with a boric or carbolic solution and reduced with the aid of sterile gauze and the left lateral position assumed on the bed for twenty minutes. Irreducible masses must be treated by rest in bed with the application of very hot fomentations of thymol one in 1,000, boric acid two per cent., or formol one in 1,000, followed if pain persists by the following ointment:

℞

| | |
|---|---|
| Zinci oxidi. | 2.0; |
| Adrenalin 1 in 1,000 | |
| Orthoform | áá 1.0; |
| Stovaine | |
| Petrolati | 30.0. |

Careful injection of four or five minims of a one per cent. solution of phenol in glycerine may cause shrinking of the varices while in several cases dilatation of the sphincter may be required to relieve the strangulation.—*Medical Record.*

# Digestive Deceptions

is only another way of describing what is often referred to as functional dyspepsias—annoying, it is true, but belonging to "a large and heterogeneous class of cases in which digestion is performed painfully and with difficulty, but in which no organic change in the organs of digestion can be found." (Hutchison)

They frequently disappear spontaneously when the general nutrition is looked after, rather than the stomach and its affairs emphasized; the patients trained to more physiological, if less conventional, modes of diet, including avoidance of worry about special articles of food supposed "not to agree."

It has been remarkable, in the practice of many physicians of many lands, how quickly functional dyspepsias subside when the breakfast is restricted for a time to

# Grape-Nuts

and milk or cream, and eaten slowly until fully masticated before swallowing. This food, requiring only partial digestion in the stomach, is practically all absorbed; is highly nutritious and is the least taxing on the digestive organs, which soon find "encouragement" to resume the normal digestion of what articles of food the individual naturally craves—the true criterion, when heeded with moderation.

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P.—4

# Miscellaneous

### Sanmetto

The philosophy of the action of Sanmetto in gonorrhœa may be explained in this way: Sanmetto has no direct germicidal action in the treatment of membranous conditions due to the invasion of the gonococcus. It should be borne in mind that Sanmetto does not directly destroy gonococci. Whatever may be its direct action upon these germs, it is certain that it does not have any such directly germicidal influence. What it probably does is to set up in the mucous membrane a reaction to the inflammation, or a nutritive toning up of the parts, which brings to the parts a sufficient reinforcement of leucocytes to overwhelm the germs—the gonococci. This view of the action of Sanmetto explains the apparent aggravation which sometimes is set up in the treatment of chronic inflammation of the bladder and urethra, and a consequent sloughing off of shreds and purulent matter, causing the patient to think the Sanmetto has made his case worse, but which really is but the smoke of the battle in which Sanmetto is to be the victor and the gonococci the vanquished.

---

### Is the Practitioner Responsible for Articles Left in His Waiting Room?

The medical profession in France has been shocked by the decision of an Italian appellate court of justice to the effect that the practitioner is responsible for the safety of the wraps, etc., left in the waiting room by his clients, provided that he has failed to use ordinary precautions for their safe keeping. The editor of *La Presse Médicale* for November 19 in noting this decision states that it would work havoc if enforced in France. For self-protection it would be necessary to install during consultation hours a cloakroom with a presiding functionary and checks. The obligation would little by little be transferred to lawyers, architects, and other professional men who might be called upon to check the overcoats and canes of clients. Is there an implied contract that the medical practitioner is responsible for articles left in his vestibule by patients who enter the consultation room? If so, how much vigilance is he supposed to exert? Is the responsibility to equal

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that imposed on the innkeepers? This question has already been answered in the negative by the French courts. Even restaurant keepers in France are not legally responsible for coats, hats, bicycles, etc. Special services of deposit of personal belongings exist in theatres and museums, and therefore there is an implied contract of responsibility, but no such conditions are to be found in department stores, factories, sleeping cars, etc., which protect packages, hand baggage, and workmen's tools. The physician cannot renounce all responsibility, and in cities he usually has a waiting-room attendant who acts as custodian of clients' belongings. In the small town and rural districts such precautions are hardly required.—*Medical Record.*

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**The Halifax Disaster**

Prompt assistance was sent to the stricken city from nearby towns and from Montreal, Toronto, and other places, and the following units were sent from the United States with as much despatch as possible: (1) The Massachusetts State Guard from Boston, with a personnel of thirty-two, commanded by Major Harold J. Gidding. This was assigned to the building known as Bellevue, once the residence of the general commanding the Halifax garrison. (2) Dr. E. A. Codman's private hospital staff from Boston. This comprised fourteen persons, and was sent to the Y. M. C. A. Building, which had been rapidly transformed into a hospital. (3) The American Red Cross Unit from Providence R.I., made up of one hundred and seven persons, commanded by Major G. de N. Hough. This unit worked at first in the Halifax Infirmary and later at Bellevue. (4) The American Red Cross Unit (Boston) No. 5, consisting of one hundred and five persons, in charge of Dr. W. E. Ladd and Mr. Samuel L. N. Wolcott (A. R. C). They went to St. Mary's College, a Roman Catholic institution, hurriedly transformed into an emergency hospital. (5) The State of Maine medical unit, consisting of twenty-four persons, commanded by Major Gilbert M. Elliott. They went to Halifax Ladies' College, which had also been given over as a hospital. (6) The Calais Chapter of the A. R. C. from Calais, with a personnel of twelve under command of Dr. William Miner and the Rev. R. A. Macdonald. This unit worked chiefly at relief dressing stations No. 1 and No. 2. Quantities of food, clothing, and medical supplies were sent to Halifax from different places in Canada

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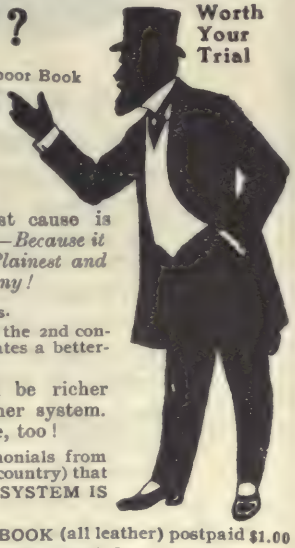

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and the United States, and on the afternoon of the day of the explosion Captain Goodman left New York on a special train to co-ordinate the work of the American and Canadian Red Cross, taking with him four baggage cars of supplies.—*Medical Record.*

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### Cerebrospinal Meningitis from Streptothrix

(*La Pediatria,* 1915, xxiii, p. 711.) G. Rutelli describes the case of a girl, aged 6 months, admitted with symptoms of cerebrospinal meningitis. Ten c.c. of fluid obtained by lumbar puncture was turbid and formed dense white clots after a few minutes. The microscope showed numerous white cells, the neutrophile polynuclear leucocytes being prevalent, several erythroblasts and abundant filamentous organisms resembling streptothrix. An emulsion of this organism injected into the peritoneum of some white mice caused death in three days. The patient's blood did not agglutinate them. A second lumbar puncture gave identical results. Urotopine was given in doses of 1 grm. daily. The temperature continued irregular and intermittent but never rose above 38.5° C. The sequel of the case is unknown as the parents removed the child from the hospital.—*The British Journal of Diseases of Children.*

---

### Cystitis in the Female

Walther in the *Nurse* (Sept., 1917) states that every cystitis patient needs rest, and the best rest is secured by putting the patient to bed. Free water drinking should be encouraged except at those intervals when internal urinary antiseptics are being given. Then the water intake is to be limited so that the bladder mucosa may be bathed in as concentrated an antiseptic menstrum as possible. The food should be light and nourishing. Warm sitz-baths produce relaxation of the pelvic parts and are of benefit. The bowels are to be kept open. Give the patient as much fresh air as possible and let her sleep out doors when practicable.

Irrigations given in bed are most unsatisfactory to both patient and nurse. The " two-way " catheters so often employed by physicians as well as nurses in handling such cases defeat the very purpose for which irrigations are primarily given, that is, to distend a contracted viscus. Therefore, the ordinary type

# Fighting Pneumonia

It takes a **fight** on the part of the patient to endure the affliction of Pneumonia and it takes a **fight** on the part of the doctor to save him. In pneumonia the inspired air should be rich in oxygen and comparatively cool, while the surface of the body, especially the thorax, should be kept warm, lest, becoming chilled, the action of the phagocytes in their **fight** with the pneumococci be inhibited.

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of catheter is the one to use. A word of caution should be given about over distending bladders. It is possible to rupture some bladders by overfilling with a solution introduced at great hydrostatic pressure, therefore the irrigator should not be elevated more than six feet from the floor. Until the capacity of the bladder is known, it is better at the first irrigation to use only fifty to one hundred mils of solution at a time. After the capacity has been determined by gradually increasing the amount of fluid, the viscus can be filled until the patient states that she experiences a sensation of fulness in the bladder region accompanied by an urgent desire to void urine. This indicates that the bladder capacity has been reached.

The time required for a cure in many of the more severe types of bladder inflammation must be measured in months, not days. If the diagnosis is correct and the treatment is given properly, success will finally crown the endeavor.—*American Medicine.*

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### Some Recent Researches into the Functions of the Suprarenal Glands

Roger calls attention to the old belief that the importance of an organ bears a relation to its size. Galen recognized that so large an organ as the liver must have other functions than the mere secretion of bile. But not until after Addison's time was it fully understood that a small obscure organ could be of vital significance, although Brown-Sequard showed that extirpation of the adrenals was promptly followed by death. The discovery of this great pioneer was overlooked, and years elapsed before it was taken up in earnest. After Oliver and Schaefer had experimented with suprarenal extracts Takamine isolated adrenalin which later was made by synthesis. Trendelenburg showed that the blood normally contains only one one-thousandth of a milligram per liter of this substance, yet this mere trace maintains the blood pressure, and whenever the content is reduced the adrenals contribute a reserve supply. Thus the paralyzing effects of fear are short lived. The author causes embolism in animals by injecting an insoluble powder (lycopodium) into the vessels and shows that the resulting fall of pressure is quickly compensated. Thus in a given rabbit the injection caused a fall of pressure from 100 to 68, but this was succeeded in six seconds by overcompensation to the extent of 164. In fourteen seconds it was down to 146 and fell slowly

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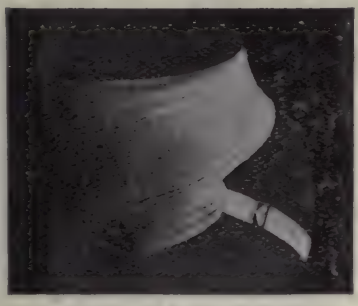

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from this level for about half an hour when it attained an equilibrium of 120-124. Thus the embolism causes a permanent pressure-rise. Roger has sought more light on this phenomenon by extirpating the capsules. With proper technique this either does not affect the blood pressure or at most sends it down to about 80 or perhaps 70. Injection of lycopodium causes a fall of pressure as in intact animals, but this is slight and transitory, as is also the compensatory rise of pressure. The actual result is a progressive lowering without further attempts at compensation. This line of experiment shows that adrenalin acts not only on the peripheral vessels through the vasomotor system but also upon the myocardium. Studied from all angles from the viewpoint of the double innervation of the heart the author is forced to the conclusion that in nature the adrenal excretes a second substance antagonistic in its activity to adrenalin. Hence injections of pure adrenalin in experimental work are not necessarily analogous to hyperadrenalæmia. Alcohol extracts only the adrenalin from the gland while aqueous extracts contain the antagonist substance, which is a constituent of the pigment. The subject has always been an obscure one. Numerous data which bear upon it have not yet been co-ordinated, and the problem is replete with interest.—*Medical Record.*

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### Ether Irrigation for Wounds

A. Distaso and T. R. Bowen show that ether, when applied to wounds, acts as a stimulant, increasing cell metabolism and hastening the formation of catabolic products. In this way a sleep similar to that from fatigue is produced. At first the author tried dressing the wounds with gauze soaked in ether and covered with cotton wool, but the results were unsatisfactory, owing partly to the cooling action of the substance and the skin irritation. Next they used a two per cent. solution with an irrigator, two litres being used once daily. This had no bactericidal action, but helped to get rid of the necrotic tissue. Recently they have treated some cases by immersion of the wounded surfaces in the solution. The ether stimulates the increased growth of firm granulations and therefore forces healing. The newly formed granulations are provided with a free and constant lavage with blood. Many wounds treated unsuccessfully with antiseptics did well with the ether irrigation.—P. A. H. (*British Med. Jour.*, 1917)—*The Prescriber.*

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### Diabetic Coma or Acidosis

When diabetic coma or acidosis is threatening, the following combination, according to the *Practitioner* (London) will often completely clear off the dangerous threatening signs. Cases on the very border of actual coma may sometimes be brought into a state of comparative safety. It is a modification of a prescription suggested by Dr. Langdon Brown in his "Physiological Principles in Treatment."

The heralding signs indicating the use of this mixture are, when they occur in the subject of diabetes or glycosuria:—

1. Obstinate and sudden constipation.
2. Feelings of dizziness, cloudiness of the brain, inability to think quickly and clearly, and difficulty in concentrating the mind.
3. Loss of appetite, with furred tongue.
4. The sweet smell of acetone on the breath.
5. The appearance of acetone bodies in the urine.
6. Feelings of general lassitude and disinclination for exertion.
7. Acceleration of the respiratory rate, indicative of the advent of air hunger.
8. Nausea or vomiting.

For 48 hours, the diet should consist of copious draughts of milk (skimmed or citrated) and Contrexeville water. A sharp saline purge should first be given.

After the attack is over, this preparation, or half doses of it, should be taken during the first and third weeks of every month—two or three times daily. The magnesium and calcium are necessary in order to replace the drain on the alkaline bases. When an attack is threatening, the bowel should be washed out with copious saline enemata—*American Medicine.*

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### Drafted Men Must Submit to Operation

The manual of the Army Medical Department, issued in 1916, provides for the discharge of men where the surgeon is in doubt whether the proposed operation involves an appreciable risk to the life of the soldier. It seems that many drafted men have been taking advantage of this provision to evade military service, so that Surgeon-General Gorgas has found it necessary to issue a new order. Under this order any soldier

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whose physical condition makes him unfit to discharge his military duties must submit to an operation if such operation is indicated, or face court martial if a board of medical officers so rules. The new order directs, "in cases in which a soldier refuses to submit to operations or medical treatment that a board of medical officers be convened to pass upon the case, and if the board is of the opinion that the operation or treatment is necessary to enable the soldier to properly discharge his military duties, and he persists in his refusal after being notified of the opinion of the board, he may be tried under court martial under the 96th article of war."—*Medical Record.*

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### A New Interpretation of the Pathologic Histology of Hodgkin's Disease

Douglas Symmers, *Arch. Int. Med.*, 1917: XIX: 990. The author thinks that Hodgkin's disease is primarily neither an infective nor a neoplasmic lesion of the lymph nodes, but a systemic disease which expresses a predilection for lymphoid tissues, gives rise to multiple foci of growth at approximately the same time and in response to the same provocative agent, whatever its nature and origin may be, causes preliminary hyperplastic changes in the lymphoid tissues and initiates disturbances in the bone marrow, characterized, among other things, by proliferating of the nongranular mononuclear cells of the lymphocytic type, eosinophils and eosinophilic myelocyte. These cells together with the myeloplaxes, are thrown into the circulation and filtered out by the lymph nodes or deposited in them in response to chemotactic attractions, the fibrotic changes of the recipient tissue representing a purely local reactive process. The histological changes beyond the lymphoid system proper, namely, in the liver, kidneys, etc., represent a reaction on the part of normally existing lymphomatous foci to the same toxic substance which is responsible for the disturbances in the bone marrow and for the myeloid transformation of the lymph nodes.—*Cleveland Med. Journal.*

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Tourist (in village notion store)—"Whah-dya got in the shape of automobile tires?"

Saleslady—"Funeral wreaths, life preservers, invalid cushions and doughnuts."—*Judge.*

# The Canadian Practitioner and Review

Vol. XLIII. TORONTO, APRIL, 1918 No. 4


## Original Communications

### VOCATIONAL TRAINING*


Address by Capt. R. Roddick Byers, C.A.M.C., Ste. Agathe, Quebec.


When the first military patient was admitted to the Laurentian Sanatorium, early in 1915, I was under the impression that the same routine, which had been employed so successfully for the treatment of civilians suffering with pulmonary tuberculosis would apply to soldiers, that it came as somewhat a shock to me to find that my impressions were wrong. The civilian patient paying his way, often with hard-earned savings, often on borrowed money, and sometimes on actual charity, gave his whole attention to medical direction, knowing full well that every moment was precious and important. Little difficulty, as a rule, was met in directing his treatment and in obtaining his co-operation. The soldier on the other hand, recently back from scenes of excitement, danger and exposure to hardships; receiving the pay and allowances of his rank in addition to free treatment, and often in a nervous and restless frame of mind, did not appear to appreciate the full necessity and meaning of the "rest-cure," and in many instances was actually insubordinate to any direction whatsoever. However, in the Laurentian Sanatorium, where the first soldiers were treated, the influence of the civilian patients, the home-like life, and social influences had such a beneficial effect on the soldiers that they "carried on" fairly well for a while. After a few weeks' stay, however, a restlessness appeared, and many of them refused treatment.

*Read at the Seventeenth Annual Meeting of the Can. Tuberculosis Assn.

Through the efforts of our Matron and some of the ladies in the sanatorium, some of the men began to take an interest in needle work, and immediately there was a decided improvement in their methods of following the prescribed rest, and I was much impressed with the interest displayed by the men in this form of occupation which fitted in so well with the amount of physical rest ordered.

With the New Year 1916, it became necessary to find more accommodation in Military District No. 4, and to this end the Laurentide Inn, an old-fashioned hotel situated near the Laurentian Sanatorium, was taken over by the Military Hospitals Commission, having been offered to them by Mr. D. Lorne McGibbon, rent free, for this purpose. The Inn was quickly filled, and being purely military in character, lacked the attractions offered at the Laurentian Sanatorium of a mixed community, with the many pleasures afforded by the civilian patients. I now found that in a large number of patients a decided desire to avoid treatment, in some a refusal of treatment, while a minority took occasion to show their disregard by getting drunk. In fact, during the first six months in which the Laurentide Inn was operated, no less than fifteen per cent. of the men had to be discharged for drunkenness and insubordination, while thirty-three per cent. refused treatment and took their discharges by signing waivers. Naturally this was a most discouraging state of affairs, especially when the work had been started to help these unfortunate men back to health, and a new start in life.

After having given this matter a great deal of thought, and having made an analysis of the reasons for refusing treatment offered by the men, I came to the conclusion that they became discouraged simply because the treatment lacked interest, and the life was too dull and came too suddenly after their very recently active and exciting experiences. I decided at once to make an effort to give my patients some form of occupation suitable to their degree of disability, and in this way soothe their nervousness, shorten the tedious hours of enforced rest, and trust that the results of treatment would not be much lessened by the experiment.

In May, 1916, I asked the Military Hospitals Commission to erect a small workshop on the grounds of the Laurentide Inn, in which the men who were strong enough could do a little light work daily, and I was delighted to find that a hearty response was forthcoming. The Commission placed the matter

in the hands of the Vocational Training Department, and it was taken in hand by the Secretary, Mr. T. B. Kidner, who suggested that the Vocational Training Department might be used with benefit to all patients if I saw fit to allow the work. Being delighted to have this help, we proceeded to draw up a classification of arts and crafts which appeared applicable to the treatment of lung disease.

### Classification.

*Infirmary Cases.*—Those patients who are suffering with the disease either in an acute or toxic stage and remain in bed until their temperatures are normal, and distressing symptoms are no longer present. To this class, unless in the opinion of the Medical Officer contraindicated, was allowed a small amount of some very light hand work, such as lace making, drawing and sketching, paper work, and especially needle embroidery.

*Porch Cases.*—Those patients who are allowed to dress, attend meals, but must rest in the long chairs on the gallery or porches and in the open during the remainder of the day. These patients were allowed to do more of the same work as in the Infirmary, and as their strength increased they could also undertake heavier work, such as reed-basketry, raffia weaving, and academic courses, including studies leading to the Civil Service examinations.

*Exercise Cases.*—Those patients who, having graduated from continual rest, are allowed to start light walking exercises. When, by graduated exercise, they have reached the stage where they can walk one hour daily without showing signs of relapse in the disease, they are allowed to attend the workshop, daily, for half the amount of the exercise allotment, where they are instructed in the various forms of arts and crafts work, such as basketry, carving, light cabinet-making, art metal work, picture framing, illuminating, weaving, drawing, typewriting, engraving and stencilling, and modeling.

### The Workshop.

The workshop is constructed of wood and has a frontage on the south of forty feet. It is twenty-five feet deep and twelve feet high inside. There are six windows of the French type opening at the front, which in winter are covered with cheese cloth in order to allow free air without draught. It is heated in winter by two wood stoves, and the arrangement is so satisfactory that even on very cold days, the windows can be

kept open, and the room be quite comfortable for the patients who are at work.

The equipment consists: 8 double carpenters' benches; 16 sets of bench tools; 4 sets of light metal work tools; library of 60 books on technical subjects; 5 typewriters; stock of basketry material, wood, clay, small hand looms, and materials for needle work; drawing materials, blackboards, etc.

As "safety first" measure, and in order to allow the patients to forego heavy arm work on hard woods, the following machinery, which is operated by a 5-h.p. motor, was installed: 1 band-saw, 1 post-borer, 1 small drill, 1 jointer for 8-inch material. With this equipment it is quite unnecessary for any patient to strain his thorax in an attempt to saw, drill, or plane the hard woods in which they work.

The shop is under the control of the Sergeant Instructor, John R. McLean, late of the City and Guilds of London Institute, who directs all the work, except the classical, which is handled by an assistant.

No patient is allowed to take up shop work until he has reached a stage in his treatment which warrants a minimum of one hour's walking daily. Having reached this period in his treatment he is then attached to a workshop class, and may use half his exercise period at study or workshop. The patient is allowed to follow his own inclinations, and is in no way forced to take up work for which he has a dislike. Every patient in the class of exercise taking over one hour walking daily is expected to attend the workshop and take up some sort of work or study, otherwise there would be a certain number of "slackers," a condition which is in no way conducive to good conduct and discipline in any institution.

The shop has been in operation nearly a year, and we have yet to record a single instance where a patient has had a relapse as result of the work carried out in it. We have no trouble in getting the men to attend the classes, in fact the sergeant-instructor has more trouble curbing their ambitions which would lead them beyond the prescribed amount of time to be spent in the shop. It is pleasing, indeed, of a morning to step into this little hive of industry and see the men at work, each one intent on his production, here one making a doll house, and there one a tea tray which, when completed, will be his own production from the silk-worked design under the glass bottom to the highly polished mahogany moulding of the edging and handles. And to think that a year ago these boys were wandering about the

streets of the town, disheartened and discontented, drifting into pool rooms, and worse. We feel that the shop has paid for itself over and over again, and has hastened clinical results that could not otherwise have been attained.

In addition to the shopwork, there are classes held leading to the Civil Service examinations, and already eleven men had been successful in this branch. At present there is a class of fourteen men taking French lessons under an assistant instructor recruited from amongst the patients, while the majority of the patients are for ever working in silk and on the looms with such beautiful results as these samples which I have brought with me.

I will not bore you with any statistics of the work. It is probably too soon as yet for these, if they are to be of real value, but a careful record is being kept by the Vocational Training Department, and I hope at a later date to show that the start made in a vocational training way at a sanatorium has led to a bettered condition of things for many of our patients. Of this I am certain, that many men have remained under treatment, and been made happy and contented while taking it, and in all probability kept out of harm and mischief, or worse by means of the various harmless occupations offered; that the results of treatment from a medical point of view have not been lessened, but made greater, and that I am of the opinion that mental and light physical occupation properly regulated is beneficial, and aids the medical officer and his staff to obtain the results which they desire. Apart from vocational training entirely, I consider that the expenditure made on this department was well spent, and that the results have fully justified it, and I strongly recommend that the system be given trial, not only in military, but civilian sanatoria throughout Canada.

# HOW A MEDICAL HEALTH OFFICER CAN BECOME A CO-OPERATIVE SOCIAL FORCE IN RURAL DISTRICTS*

By Peter H. Bryce, M.A., M.D.
Chief Medical Officer, Department of Interior, Ottawa.

I imagine that it may not be without value to the younger public health officials and other workers to have a retrospect presented of the evolution of public health organization and methods of work during the thirty-five years since the first Provincial Board of Health in Canada was established in Ontario, in 1882, and which has become the model for most others in Canada. The Ontario Public Health Act of 1884, based upon the Consolidated Public Health of England of 1875, has also become the model upon which the public health acts of the several provinces have been based.

The first public health legislation which I am aware of in Canada was that of 1833, which provided in Upper Canada for the formation of Local Boards of Health by Order-in-Council during epidemics. It was the outcome of the cholera in 1832. In 1849, when under the Baldwin-Lafontaine Government, the Municipal Act of the United Provinces of Upper and Lower Canada was passed, by which townships, villages and towns became the units of municipal governments, an Act was also passed providing for a Central Board of Health being appointed by Order-in-Council to continue during the period fixed in Order, whenever public health necessities demanded. It will be remembered that 1848-1849 were also cholera years. Under this Municipal Act provision was made for health committees being appointed and health by-laws being passed by each council.

Such then was the situation in Canada until 1882 when the first permanent provincial board was formed and until 1884, when the Ontario Public Health Act was passed providing that each municipal council should annually appoint a local board of health of five members, who would enforce the Public Health Act and health by-laws instead of the municipal councils. However, as these local boards in villages and many townships

*Read at the forty-eighth annual meeting of the Canadian Medical Association, Montreal, June 14th, 1917.

represented often a population of only a few hundred persons, it is apparent that while the system, like that of the municipal councils and local boards of school trustees, is admirable in bringing home to every ratepayer his responsibility as a citizen for the public welfare in matters of health, yet in the event of epidemic outbreaks of disease it has often been necessarily financially onerous on the ratepayer when having to establish quarantines, erect isolation hospitals and pay physicians especially appointed to care for such patients. The same difficulty existed in dealing with the routine enforcement of health laws relating to nuisances, protecting of wells, disposing of refuse and so on, so that in 1894 the Executive Officers Association of Ontario began the discussion of the advisability of enlarging the unit area for a board of health's operations to the extent that whole time officers would devote all their energies to a county or at least to the area for parliamentary representation. This idea has in part been attempted both in Ontario and Quebec by appointing provincial all-time district medical officers; but it has not removed the financial disabilities often placed upon small municipalities, not provided for the evolution of a larger conception of the true scope of the work which specially trained all-time county health officers would effect in public health and social development.

In a paper on the subject before the American Public Health Association in 1910, I set out the duties which such officers would perform in the following terms:

"To lend dignity to the office and maintain its work in close relationship with the county organization, a County Board of Health; to meet quarterly or more often in emergency, should such exist, to be composed of the Warden or elected head of the county council, ex officio, and either the senior or junior county judge, along with the medical officer. Such a board, composed wholly of officials, would add nothing materially to the cost, while questions of health, finance and law would have brought to them the experience of men trained to consider each. The health machinery would, of course, be: (*a*) The laboratory, required to have a minimum equipment supplied by the county, satisfactory to the Provincial or State Board, located centrally and convenient to the work by both rail and telephone; (*b*) In those counties where some institution as a county tuberculosis hospital or sanatorium existed, it would often be found of real practical utility to have the medical officer placed in charge, have the laboratory there, and

so centralize and enlarge his work; (*c*) As the county contains a number of townships, towns and villages, which may have already a sanitary officer, these would become, as in England, automatically the local officers of the county officer, with duties defined under the law, such as reporting daily, when necessary, all notices of contagious diseases, and carrying out routine inspection, disinfection and policing; (*d*) The medical officer would similarly receive directly from physicians, or through the local inspectors, reports of outbreaks of contagious disease, and from all practising veterinarians notice of contagious disease in animals, affecting the public health. (*e*) The medical officer would similarly be medical inspector of the schools of his district, and would naturally carry out the physical inspection of the school children as well as inspection of school buildings and the control of contagious diseases. (*f*) He would also put in force a systematic supervision, not only of the factories in towns, but especially of the rural factories as of cheese, butter and fruit canning. (*g*) He would likewise systematize, through the township inspectors, the examination of dairies and the supervision of public milk supplies. (*g*) He would especially through local veterinarians, discover herds where tuberculosis existed, and would gradually organize a meat inspection service through centralizing the slaughter of meat to be sold to the public."

It will be realized, perhaps, how such a scheme is all the more urgent in view of the decreasing rural populations in the township and village municipalities of the Eastern provinces. Thus the census returns for 1911 give the following results:

| | 1901. | 1911. | Increase. |
|---|---|---|---|
| Rural, for all Canada.. | 3,349,516 | 3,924,394 | 17.16% |
| Urban ..... | 2,021,799 | 3,280,444 | 62.25% |
| Quebec, rural ..... | 992,667 | 1,032,618 | 39,951 |
| | 1901. | 1911. | Decrease. |
| New Brunswick, rural... | 253,835 | 252,342 | 1,493 |
| Nova Scotia, rural .... | 330,191 | 306,210 | 23,981 |
| P. E. Island, rural.... | 88,304 | 78,758 | 9,546 |
| Ontario, rural ..... | 1,246,960 | 1,194,785 | 52,181 |

The actual situation as regards the decline of rural population may be understood when it is known that of 400,000 immigrants who went to Ontario during the census decade, 30 per cent. stated they were farmers or farm laborers, and yet there

was a rural loss of 52,184 in addition to the loss of the total natural rural increase, while even in Quebec, the especial home of the French-Canadian peasantry, the annual rural increase for the period was only 0.4 instead of 2.15 per cent., the annual average for the whole province.

To further expose the situation I find that in Ontario in 1914 the population was given at 2,749,840, of which the cities and towns over five thousand population, held 42.1 of the whole, while 57.8, or 1,587,025, were in the smaller towns, villages and townships, which include about eight hundred municipalities. If each had its medical health officer this would mean one for two thousand. Actually there were in 1916 eight hundred and thirty-seven local boards of health, each with a medical health officer. I find that in the Province of Quebec there were ninety-eight cities and towns and ten hundred and ninety-three villages and townships, or roughly, two hundred more than in Ontario. As the rural population in Quebec in 1911 was given as 60 per cent. of a population of 2,022,712, we find that with ten hundred and ninety-three municipalities the population of each is just eleven hundred, in each of which, under the Quebec Health Act, must be a "municipal sanitary authority." It must be remembered, however, that this average does not at all represent the actual situation, since in Ontario there are actually two hundred and sixty villages and towns, the minimum of population being five hundred, while in Quebec the population of the villages must, in many cases, be but a fraction of this. The minimum health unit, however, is that of Nova Scotia, where the Act requires that a health committee must be appointed for each municipal polling subdivision.

In order to complete our statistics, I have endeavored to find out the distribution of churches and clergy. I find that, roughly, in Canada there are eight thousand Protestant clergy and four thousand Roman Catholic; but it is difficult to ascertain accurately their distribution. I find, however, that Quebec has nine hundred and ninety-four Roman Catholic parishes and that their distribution is largely the same as the municipal subdivisions. In Ontario, as in the older provinces, every village and many rural communities have churches of some denomination and clergymen ministering to their spiritual needs.

As regards the medical services available I find that there are, in round numbers, seven thousand physicians in Canada, distributed, like the clergy, where they are required.

Many other figures would be necessary to make complete

the total persons in some way engaged in public health, religious, charitable and social work, such as the total members of boards of health and sanitary inspectors, the number of lay-workers in churches and religious orders and the many charity workers in our cities and towns; but each of us can easily form some estimate of what these are. Now, what we have especially to note is, that while we probably have in our rural areas, which constitute say at least 60 per cent. of the population, and that while probably two-thirds of this is actually agricultural and one-third in villages, yet very few of those representing in any way the educational or professional or social worker persons in these communities reside actually in the townships.

Such, then, is the constitution of municipal and social forces of the rural communities of Canada, varying but little in the newer provinces except in so far as the population is more sparse and more widely distributed. Indeed, these very facts are making the need for newer methods in social evolution there so evident that in Manitoba, district nurses have already begun the work of inspection in schools, and following into their homes those children whose physical and mental needs call for attention. In Saskatchewan already twenty district hospitals have been constructed and it is expected that within two years as many more will have been established at convenient centres, to which physicians will send their patients for treatment under a regular nursing staff, who will also gradually undertake social work by district visiting; while, in addition to this necessary work, Alberta is developing social centres by having erected a "Home House" for the several school teachers of adjoining sections, added to which will be the district social nurse.

Reverting to the old East, it is apparent that for many years the loss of many of the young people of its rural population has become in many districts little less than a war tragedy. It is as if an extended war conscription had robbed the countryside of 10 per cent. of its young adolescent population in ten years, since in some counties of Ontario this loss has been at least one per cent. per year. Closely examined, this condition is both an effect and cause of a social disintegration and destruction of an old-time rural life, rich in numbers, in energy, in hope and in action. We have no time to enter upon an explanation of its causes; but I propose to enquire whether its reconstruction cannot be brought about by the co-operation of forces already present. It is abundantly plain that what every large

town and city have to-day developed in abundance of municipal, religious, educational and social organization are almost everywhere lacking in our rural municipalities as centres for unifying and socializing the people. As a basis for rural progress there must be a recognition of the fact that the economic life of this rural population must be adequate in return for the energy exerted and must develop social amenities sufficient to attract and retain a contented rural population. It is apparent that education of an adequate scientific character must be supplied to do this. When it is known that the old village or countryside school, once with its fifty or seventy-five children is to-day often reduced to ten or twenty, it is evident that a young school miss, presiding over a few children of different ages and paid a salary wholly inadequate to encourage permanence in the teaching profession, is in no way going to do more than play with the problem of inculcating those scientific truths which necessarily form the basis of the permanent upbuilding of the child mind into an interested and progressive agriculturist. In no other single occupation is it pretended to-day that anything but failure can result from the neglect to make use of the most advanced scientific methods.

The war has exposed the real situation as applied to production, resulting from the lack of instruction in science, of the British nation at large, and when it is understood that not more than five per cent. of children reach the secondary schools, the full meaning of this can be appreciated. But this work of interesting the child mind in the phenomena of nature around him through scientific teaching must be begun from the earliest school years. Not only so, but extension of methods must be progressive as his mind grows, and school gardens, orchards, greenhouses, dairies and laboratories must be the means whereby the children are not only taught, but the community also brought together. In the good old days the transepts of St. Paul's Church and the churchyard in London were highways and places of meeting and trade for the people, while nothing seems to me more dreary and sad than to see the two isolated buildings along the country roads of our provinces often without grounds or any garden and, except on Sundays, without any sign of human interest attaching either to school or church.

Now what is needed is that the countryside become socialized. In our day of rapid transport we have only the semblance, in many cases, of the old-time mediæval countryside

open fields, where corn land and meadow and pasture around the villages were distributed yearly by lot and worked and used in common. How is this socializing to take place? In brief it must be by evolving a new sense of the dignity and national importance of agriculture and rural life. Who are to be its apostles? Unquestionably in addition to the co-operating farmers themselves it must be the clergy, the physicians and teachers. Even though often inexperienced and untaught in these duties, they are still the people's leaders. It is, however, interesting to note that in Quebec many of the clergy in their "Community Houses" are amongst the leaders both in the practice and theory of agriculture; while no doubt many cases exist where the rural clergy interest themselves directly in the practical problems of their people. But this has not been the practice in other communities, and too often the clergyman never gets close to the public school pupils, nor meets his people except on Sunday, and then in his capacity as their spiritual adviser. The country doctor often comes much nearer to the interests of his community and may at times become actually a leader in practical rural affairs. He would become still more so if, as an all-time medical health officer, he could with an equipped laboratory come into close practical relations with this farm life. For instance, the counties are establishing gradually, at least in Ontario, sanatoria for tuberculosis. Here might well be the starting point. Every county has still five to ten such cases per thousand of population, and through the practising physicians the county officer would come to deal not only with tuberculosis, but also other problems. The outbreaks of acute contagions in cattle would at once be diagnosed through laboratory tests; the movement of the officer through his district would bring early to his notice fungous and insect diseases of plants, while his practical oversight of the surroundings of cheese factories and creameries would be but a step to his investigating and suggesting improvements in the method of cheese making and butter making from the bacteriological standpoint. With the careful rural taxpayer I know of nothing which would so soon gain his approval of a progressive public health organization as the practical interest which a trained bacteriologist would take in actual rural production. When a great American industry can afford to set apart half a million annually for investigations in science, it must surely appear essential in an industry like agriculture, whose very future depends

upon the application of the knowledge gained in every field of science that organized methods for this purpose be developed. Already these have begun through the appointment of agricultural demonstrators in some of our counties and in the degree that such are multiplied we have every reason to feel assured that community work in our rural districts will increase. I have suggested that this work demands the closest co-operation of clergy, teachers and physicians, with the people of our rural communities, and I can conceive of nothing so likely to make this possible as the unifying of old school sections into a central or consolidated school, where a number of teachers with a trained science principal and enough buildings and equipment, would create a true educational and social centre for the people. To illustrate how the public sense is still little developed with regard to the health phase of this socializing process I shall give a statement regarding the local boards of health in six of the ten health districts of the Province of Quebec, supplied through the kindness of Dr. Pelletier, secretary of the Superior Board of Health and of Dr. McCullough of the Provincial Board of Ontario, who informs me that each of the eight hundred and thirty-seven boards of health has its medical officer. In the Montreal Health District there are seventy-nine parishes, eighteen villages, thirty-two towns, six cities.

Of the important municipalities Montreal spend $250,000 in health work and employs twenty-seven medical men under a chief medical officer, while the salaries run from $5,000 to $1,500. Lachine spends $15,000, and employs three medical officers, with salaries from $1,400 to $450. Westmount pays $1,000 to its medical officer; Maisonneuve $2,000 and Verdun $1,000.

# Editorials

## THE CARE OF RETURNED SOLDIERS

It would appear, as intimated in a former issue, that the complications existing between the C.A.M.C. and the Hospitals Commission have been cleared up. The Privy Council made its pronouncement February 21st, from which we take the following: "Whereas it is essential that a time be fixed up to which responsibility and duty are conferred upon the Militia Department, and the Military Hospitals Commission, respectively, after consultations between the Prime Minister and the Minister of Militia, arrangements have been made regarding the time when the soldier receives his discharge from the Military Service. There shall be a Department of Soldiers' Civil Establishment. Its duties shall include the following: A. Providing hospitals, convalescent homes and sanatoria for the care or treatment of returned soldiers who have been honorably discharged from the C.E.F. B. Vocational, educational and other training for special occupation of the discharged soldiers. C. The provision of employment and all such assistance as may be requisite for such persons, and generally for their rehabilitation in civic life. D. Matters pertaining to pensions without their interfering with the powers of the Board of Pensions Commissioners. All soldiers of the C.E.F. will, until they are struck off the strength or discharged, be cared for, and treated in institutions administered and controlled under the direction of the Minister of Militia, and

will pass under the care of the Military Hospitals Commission, to be known hereafter as the Invalided Soldiers' Commission, only upon their being so struck off the strength or discharged."

It was reported at Ottawa that the Hospitals Commission or the Department of Soldiers' Civil Establishment, as it is now called, will have handed over to the control of the military authorities fifty of the larger Hospitals which have for the last two years or more been occupied by returned soldiers.

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## MEDICAL INSPECTION OF SCHOOLS IN TORONTO

At a meeting of the Toronto City Council, held March 6th, Dr. M. B. White said that when the Board of Health took over the School Inspection, he had been given charge both of the Isolation Hospital, of which he had been for some time Superintendent, and also the Medical Inspection of the Public Schools. This had previously been conducted by a medical officer at a salary of $3,600 a year. The reorganization of the staff has resulted in the saving of $10,000 a year in salaries which aggregated formerly over $26,000, while now they would aggregate about $16,000. There was a school population of 70,000. Each child was examined half-yearly. Much work previously done by doctors was now performed by nurses, thus effecting a considerable saving.

Certain members of the Toronto City Council were very anxious to have some control over the money spent by the Health Department, and asked for legislation from the Provincial Parliament. The first

and most important clause of the proposed Bill would give the Council of a municipality power to approve or disapprove accounts incurred by the Board of Health or Medical Officer of Health, and the payment would be made by the treasurer of a municipality after such approval had been granted. This was lost by a large majority. The enactment of any such clause would, of course, bring us back to the old, old days when village politicians, and perhaps still smaller politicians of a city like Toronto, were able to interfere very seriously with the good work done by Medical Health Boards. The principal supporter of this proposed act was Controller Sam McBride, who, as usual, talked *long and loud* in favor of this proposed retrogression. Nobody is surprised at any aggressive foolishness in Controller McBride, but we are more than surprised that a level-headed man like the Hon. Tom Crawford should support any such dangerous legislation.

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## CANADIAN MEDICAL PROTECTIVE ASSOCIATION

We desire again to call the attention of our readers to the last Annual Report of this Association by the President, Dr. Robert Powell, of Ottawa. He states that the executive decided, in 1914, to keep the names of all members going overseas on their books in good standing until they returned to their homes, without asking for their annual dues. As a consequence, there is a decrease of active membership which, however, is not enough to cause material anxiety. The membership in 1915 was 1,831.

This is really a splendid Association in the interests of physicians who join it, and is exceedingly well managed. Let us ask the members to *talk it up* and get their friends to join. From an insurance standpoint, both as to reputation and money, the small membership fee is about the best investment open to the members of our profession.

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## EDITORIAL NOTE

Dr. A. B. Welford, a prominent and respected physician of Woodstock, was charged in the Police Court and tried for a breach of the Ontario Temperance Act, February 18th. Some time ago the Doctor gave a requisition for alcohol to T. Michelson, of Brooksdale, who said it was for his mother who was ill, to use for the "alcohol rub." The man drank the alcohol instead of taking it to his mother. The prosecution claimed that the doctor should only give the order for the alcohol after seeing and examining the patient, which he did not do. At the trial he was found guilty, and fined $50 with costs, aggregating altogether about $70. The Doctor at once announced his intention of carrying the case to a higher court. The appeal came before Judge Middleton, March 8th, who reserved decision.

His Lordship announced his decision March 14th, upholding the magistrate in Woodstock. In doing so, he said the name of the supposed patient did not appear on the requisition, but instead the name of the "thirsty son," and his illness was given as "bathing."

# News Items

Dr. Forbes Godfrey, Member for West York in the local Legislature, strongly urged the Government, during the recent session, to establish a proper reception hospital in Ontario. The Provincial Secretary, Mr. McPherson, said the Whitby Institution was equipped for that work, but was at present being used by the military authorities for hospital purposes.

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Many Canadians, and especially those living in this part of the Dominion, were very much pleased to learn that the Toronto Branch of the Secours National recently received a cable announcing that it had been given the village of Vimy in France to rehabilitate. The members considered it a privilege to have this historic site, at which Canadians did such heroic work, given over to their keeping.

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It may be remembered that at the Adam Wright banquet Irving Cameron gave many reminiscences of the early college days, mentioning the names of many of the Old Boys such as Beemer, Robinson, Albert Macdonald, Jukes Johnson, etc. Among them he included the name of Yokome, the joker who never graduated, because " with much native cleverness he combined no seriousness." Mr. Yokome, after giving up the study of medicine, went to the Press, and for thirty-six years was editor of the *Peterborough Daily Examiner*. We learn from the *Toronto Mail and Empire* that he died after a short illness, March 11th, aged 76.

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Col. W. B. Hendry returned to Toronto March 18th, having been requested by the University authorities to come over for consultation in regard to certain matters in connection with the University Hospital at Basingstoke. The University Unit was first in command of Col. Roberts, the well-known South African veteran. After a stay for some time in England, Col. Roberts accompanied the unit when it went to Saloniki. While at the latter place Col. Roberts became ill, and returned to England,

where we are glad to say he soon recovered, and is now on active duty as C.O. of one of the Military Hospitals. After he left Saloniki, Lieut.-Col. Hendry, now Colonel Hendry, D.S.O., was made O.C. of the University Hospital, which is technically known as No. 4 Canadian General Hospital. During his absence, Lieut.-Col. Harold Parsons will be in command at Basingstoke, which is quite an old town, close to the south of Hampshire or Hants, one of the southern shires of England.

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According to a cablegram received March 13th, Lt.-Col. Walter McKeown, after his holiday trip to Ireland, was appointed C.O. to the Canadian Hospital in England, which was formerly under the command of Col. C. F. Wylde. It was also stated that his son, "Woody," was much improved in health, and was again engaged in military work in England. It is understood that he will not be sent to the front for some time.

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Capt. Percy B. Brown returned to his home in Toronto after twenty months' service in India, Africa and Mesopotamia, February 20th, and is now on the staff of the Davisville Hospital. He came home from Mesopotamia via Egypt, France and England, travelling across the Mediterranean on a horse transport on which there were 1,500 Indian coolies going to France. The boat was not exactly speedy. Between Malta and Marseilles she averaged five knots a day. She looked like a tramp steamer or a "mystery ship," and was able to hold her own against the submarines.

# Personals

Major W. A. Groves, C.A.M.C., who went overseas with the 65th Battalion, has returned to his home in Fergus.

Dr. Jno. W. Wood has been appointed Surgeon of the Lindsay Jail in the place of the late Dr. Jeffers.

Capt. Frank L. Thompson, C.A.M.C., has been attached to the Army Medical Department in the Training Depot, Toronto.

The following are on the Medical Board of Final Review, Toronto: Majors Chas. Shuttleworth and William Thistle, Capt. A. G. Ferguson.

Col. Arthur E. Ross, C.M.G., M.P.P., C.A.M.C., was on February 14th presented with the Croix de Guerre by the Belgian Government.

We are pleased to learn that Col. Chas. Hodgetts, C.M.G., Canadian Red Cross Commissioner, has recovered from his recent attack of pleuro-pneumonia.

Surg.-Gen. Carleton Jones reached Ottawa from England February 16th.

Miss Edith Gordon, of Toronto, B.A., M.B. (Tor.), has accepted the appointment on the staff of Cornell University as a "medical adviser of women."

Capt. E. G. Leary, C.A.M.C., who was for some time on the staff of the Orpington Military Hospital, has returned to his home in Brampton.

Capt. Philip Garratt, son of the late Dr. Alton Garratt, of Toronto, was stationed at the Airdrome, Croydon, England, when last heard from, March 5th. Mrs. Garratt, who has been doing war work for over two years, was also in Croydon at that time.

Lt.-Col. E. G. Doherty tendered his resignation as M.O. of the Newmarket Military Hospital, February 24th, to take effect on March 1st.

Dr. George Clinton, H.O., No. 4 District, visited Penetanguishene, March 7th, and investigated the condition of certain tanneries where two of the workmen had recently died from anthrax.

The Queen's Canadian Hospital at Beechboro' Park, hitherto an auxiliary to Shorncliffe British Hospital, was transferred to Moore Barracks, Canadian Military Hospital, England, February 12th.

Capt. C. A. Briscoe, R.A.M.C., was recently awarded the Military Cross. He joined the British Medical Corps about two years ago, and has served most of his time at military posts on the Mediterranean.

R. D. Bartlett, a medical student of 1920, went overseas with the Fifth University Company. He was wounded by shrapnel at the Somme, and has since been discharged because unfit for further active duty.

Maj. J. W. Coulter, C.A.M.C., of Chatham, Ontario, was appointed President of a travelling Medical Board in England, March 10th. He has only recently recovered from wounds received at the front about a year ago.

Capt. Eric K. Clarke, C.A.M.C., M.B. (Tor.), 1916, went overseas a year and a half ago. A short time ago he returned to Toronto on sick leave, and after undergoing an operation received an appointment on the A.M.C. staff, Toronto.

Capt. Harvey Young, of St. Mary's, after graduating M.B. from Toronto University in 1916, spent a short time as interne in the Toronto General Hospital. He joined the C.A.M.C. in 1917, and has recently been awarded the D.S.O.

Dr. Caulfield, recently married in England, arrived in Toronto with his bride, February 20th. After a short stay at the King Edward Hotel, Dr. and Mrs. Caulfield went to New York. On their return they will take a house in Toronto.

Capt. Gerald Allison, of Picton, returned to Canada from overseas on six weeks' leave, February 24th. He enlisted as a private in 1915, and has served at the Dardanelles, India and in France. He was wounded and gassed at Cambrai last December.

Capt. W. C. Connell, who enlisted as a private early in the war, returned to Toronto to complete his fifth year of study for M.B. Last year he went back overseas as a lieutenant in the R.A.M.C., and when last heard from was serving in German East Africa.

A case of smallpox was discovered, February 18th, at the Collegiate Institute in Chatham. Dr. T. L. McRitchie, the acting M.O.H., took prompt and drastic action to prevent the spread of the disease. His efforts were successful so far as we know at the time of writing.

Surgeon-General Fotheringham, C.M.G., is still acting as Director-General of the C.A.M.C., with headquarters at Ottawa. He visited Toronto February 8th, and after looking into certain matters in connection with the Military Hospitals, returned to Ottawa on the night of March 11th.

Dr. J. M. Johnston, Elm Street, Toronto, was committed for trial on a charge of performing an illegal operation. He was tried at the Court of General Sessions under Judge Winchester, March 7th, and the jury brought in a verdict of "guilty, with a strong recommendation to mercy."

Gen. Sterling Ryerson, of Toronto, delivered an address at Vancouver, March 12th, and another in Victoria on March 14th. After that he expected to go to the United States, probably to Oregon, Idaho, Washington, California, Arizona and Nebraska, to assist in the American Red Cross campaign.

Capt. Wm. B. McDermott, who, after graduating in 1912, practised in Lang, Sask., until 1914, when he enlisted and went overseas. He worked for some time in the Anglo-Russian Hospital in Russia, which was organized by Lady Muriel Paget. After the English surgeons gave up their work in Russia, he returned to England, and was there when last heard from, February 5th.

Miss Marion Noel Bostock, M.D., daughter of Senator Bostock, Liberal Leader in the Senate, is at present Acting House Physician in the Queen's Hospital for Children, at Hackney, London. A few weeks ago she had the honor of passing the primary examination for F.R.C.S., Eng. She is the first woman from Overseas Dominions and the seventh woman in the British Empire to pass this examination.

Lt.-Col. W. B. Hendry, of 181 Carlton Street, Toronto, has received the D.S.O. His many friends are highly pleased. We have heard much during the last two years regarding the great efficiency of the University Base Hospital at Saloniki. In connection therewith we understand that no man in that Unit or any other Hospital Unit in Europe has done better work than Bill Hendry.

Col. Alex. Primrose, C.A.M.C., returned to Toronto on his second leave, February 9th. It will be remembered that Dr. Primrose went overseas with the University Hospital Unit, which, after remaining in England for a time, went to Saloniki. During the last year he has spent most of his time as a hospital consultant in England. His only son, a student of University College, was killed in May, 1916.

W. L. McKenzie, son of the late Dr. B. E. McKenzie, of Toronto, returned to Toronto after three weeks in khaki overseas, and resumed his studies at the University March 1st. The following members of the C.A.M.C. have won the Military Cross, according to an official statement delivered March 14th: Capts. Thos. T. Bell, John Cathcart, Frank Dunham, Emmert McCusker, Arth. Packer, Stanley Ross, Henry Scott, and James Woodley.

# Obituary

### W. H. CARLETON, M.B.

Dr. W. H. Carleton, of 154 Danforth Avenue, Toronto, died February 14th, aged 63. He graduated M.B. from Toronto University in 1883.

### W. H. HAMILTON, M.D.

Dr. Hamilton, a well-known physician of Fort William, died February 4th, in Florida. He graduated M.D. from Trinity University in 1894.

### RICHARD JONES, M.D.

Dr. R. Jones died at his home in Cobourg, December 15th, aged 84. He graduated M.D. from the University of Buffalo in 1864 and became a regular practitioner in Ontario in 1869.

### FRANK L. SWITZER, M.D.

Dr. F. L. Switzer, of Riceville, died in Ottawa of pleuro-pneumonia, December 22nd. He graduated B.A. from Victoria in 1887, and M.D. from Trinity in 1891.

### GEORGE BAPTIE, M.D.

Dr. G. Baptie died at his home in Ottawa January 5th, aged 73. He graduated B.A. from Toronto University in 1870, and M.B. from Trinity in 1875.

### PETER CONROY, M.D.

Dr. Peter Conroy, of Charlottetown, P.E.I., one of the best-known physicians in the Maritime Provinces, died March 14th of pneumonia, aged 65.

## CHARLES J. KELLY, M.D.

Dr. C. J. Kelly, who practised in Hamilton chiefly as X-ray specialist for many years, died in Arizona State, December 29th, 1917. He had been in poor health for over two years before that time. He graduated M.D. from McGill University in 1891.

## MORTIMER H. HAIGHT, M.D.

Dr. M. H. Haight, of Avenue Road, Toronto, died suddenly at his home from heart failure, aged 49. He graduated M.D. from McGill in 1893. He then settled down in his birthplace, New Durham, Ontario, and practised there for 14 years, and after taking a post-graduate course abroad, settled in Toronto.

## JOHN NEWTON, M.D.

Dr. Newton, of Deseronto, died February 13th, aged 76. He graduated from Queen's University in 1866. He commenced practice in Deseronto in 1870, and remained there until the time of his death. He was for many years physician to the Mohawk Indians on the reserve. He was Mayor of Deseronto in 1903-4, and again Mayor from 1907-12. He took an active interest in politics, and was for some time President of the Conservative Association.

## LOUIS G. McKIBBON, M.D.

Dr. L. G. McKibbon, of 196 Spadina Ave., Toronto, died March 3rd, after suffering from paralysis for four days following a stroke February 28, aged 52. He graduated M.D. from Trinity in 1886. After practising for two years in Blackstock, he removed to Toronto, and practised his profession there up to the time of his last illness. Dr. R. E. McKibbon, Vancouver, is a brother.

## ADELBERT E. HANNA, M.D.

Dr. A. E. Hanna, M.P., died at his home in Perth, February 27, aged 55. He graduated M.D. from McGill University in 1886, and in the same year qualified as licentiate in the two Colleges of Physicians and Surgeons in Edinburgh and Glasgow. After building up a large practice in the County of Lanark, he was elected to the Federal House in that county in 1913, and re-elected in the last election. Dr. Frank Hanna, of Bradford, is a brother.

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Mrs. Cotton, wife of Dr. Milton Cotton, of Toronto, died after a long illness, March 5th.

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Mrs. Fortye, wife of Capt. W. T. Fortye, and daughter of Dr. McFaul, Collingwood, died March 10th.

# Selected Article

## DYSPNOEA IN BRIGHT'S DISEASE

By Professor Bernheim, M.D.
Of the Faculty of Medicine, Paris.

I do not remember, in Bright's disease, to have met with dyspnœa which I could safely attribute to uræmia. I do not assert that there is no such thing as uræmic dyspnœa, but I do assert that this adjective is often applied to varieties of dyspnœa due to some quite different mechanism.

The varieties most frequently met with are the following:— In acute parenchymatous nephritis undergoing resolution, or chronic culminating in the large white kidney, the dyspnœa is due to pulmonary œdema or hydrothorax. The diminution of the urinary secretion leads to the retention of chlorides and water in the blood, so we get hydræmia and chloruræmia. When the kidney does not excrete water it does not get rid of the chlorides dissolved therein. On the other hand, especially since the researches of Didal, we know that an excess of chlorides in the organism causes retention of water and œdema. It follows that even when the kidneys have once again been restored to working order by decongestion of the glomeruli and freeing of the tubuli, they still will not allow the passage of water as long as the chlorides are in excess and as long as fresh chlorides are being introduced in the food. It is only when the chloride equilibrium has been restored by an achloride diet that the infiltrated tissues and the blood yield up their excess water to the kidneys, that dehydration takes place and that the dyspnœa disappears. There is nothing toxic in this mechanism; it is merely due to the breathing space being impinged upon by the water.

Interstitial nephritis which culminates in the small granular red kidney is associated with long-continued polyuria and but little œdema, is invariably accompanied by arterio-sclerosis and hypertrophy of the left heart, and gives rise more particularly to cardiac dyspnœa. This hypertrophy, it is true, may long allow of satisfactory respiration as long as the heart goes on working smoothly. Even in this case, however, some subjects

complain of respiratory oppression, even when auscultation reveals nothing of note in the lungs. This may be due either to the increased size of the heart pressing on the lung, thus reducing *pro tanto* its breathing capacity, or to the heart beating with more force over a greater area of the thoracic wall. This may cause a sensation of oppression which directs the doctor's attention to the heart and then to the kidneys. As a rule the oppression is not very intense as long as the hæmodynamic equilibrium is maintained.

But this hypertrophied heart may become insufficient either because its innervation is not in proportion to its size, or because the organ, being too large, is not adapted to the resistance to be overcome in the circulation, or lastly, as I have shown elsewhere, because the ventricular wall is bulged by the dilatation of the left ventricle and projects as a convex dome into the right ventricle, lessening its cavity and giving rise to venous stasis *a tergo;* or, lastly, because the myocardium has become sclerosed and has lost its contractile power. Whatever be the precise mechanism, the cardio-vascular equilibrium is disturbed, and more or less marked asystole results.

This cardiac dyspnœa is manifested by passive congestion of the lungs, with subcrepitant râles at the base, blowing respiration or respiratory silence and dullness. This is cardiac dyspnœa, and not renal dyspnœa.

Apart from this cardiac dyspnœa in the course of interstitial nephritis, we meet with two varieties of dyspnœa supervening without any previous pulmonary lesion which have been described as uræmic. These are attacks of asthma and Cheyne-Stokes breathing. The so-called renal, uræmic, dyspnœa is characterized by attacks of dyspnœa in every respect similar to essential asthma—sudden onset, violent oppression, thoracic constriction, incomplete, labored respiration, slow whistling prolonged expiration, an asphyxial hue, dry râles and whistling râles, mucous and subcrepitant râles, with catarrhal expectoration at the end of the attack, which lasts from one to several hours. At the expiration of this period things quiet down, breathing becomes free, and the râles disappear. These attacks may be diurnal or nocturnal, and recur at variable intervals; months, or, it may be, years may intervene between the attacks, or the interval may be one of a few hours only.

They are distinguished from essential asthma by their gravity and the more marked anguish that characterizes the oppression. The patient may succumb to an attack of syncope

during the attack or to asphyxia from bronchial flooding. After repeated attacks the lungs may remain congested, and so give rise to permanent dyspnœa with paroxysmal exacerbations. If the heart be hypertrophied the attacks may be followed by pulmonary congestion, creating an obstacle to the pulmonary circulation, leading to fugitive or permanent venous arystole, thus upsetting the cardio-vascular equilibrium that has so far been maintained.

Are these attacks of asthma independently of pulmonary and cardiac complications, of toxic or uræmic origin? The sudden onset in interstitial nephritis and the absence of premonitory symptoms seemed to point to this explanation, but I do not accept it as correct, because I have often met with them in presence of polyuria, with a normal standard or urea excretion, without any symptom pointing to urinary toxæmia, and always in nephritis associated with cardiac hypertrophy and arterio-sclerosis.

For that matter these attacks of so-called uræmic dyspnœa are in no sense specific. We meet with much the same thing in cardiac affections, especially aortic (insufficiency and stenosis), and in aortic atheroma without any vascular lesion. It is then called cardiac or aortic asthma. Similar attacks are met with in elderly subjects apart from any sign of aortitis. A man who is over 40, and especially over 50, previously in excellent health, may be suddenly seized with asthma without any warning; this may pass off in a few hours, leaving him apparently in good health. Now it is never essential asthma that sets in at this age, it is invariably a symptom of fatal significance. If there be no nephritis nor hypertrophy of the heart there may be atheroma, as shown by an aortic murmur and a heightened blood-pressure. Even in the absence of these symptoms there may be a patch of latest atheroma in the aorta or in the coronary arteries. It is not the amount nor the extent of the atheroma that determines the attack of asthma; it is its localization in the arch of the aorta or in the coronary arteries, involving, it may be, filaments of the respiratory nerves.

The irritation of these filaments transmitted to the respiratory centre may be propagated to the extrinsic inspiratory muscles or the bronchial muscles, and by throwing them into a state of spasm usher in the asthmatic attack, and it may radiate into the pulmonary sympathetic, leading to vaso-motor dilatation and bronchial hypersecretion associated with asthma. Aortic or coronarial asthma is to the lung what angina pectoris is to

the heart. When the irritation radiates from the aorta or coronaries, and, instead of involving the respiratory innervation, attacks cardiac innervation, we get angina pectoris and, for that matter, the two may co-exist side by side.

However this may be, an attack of asthma in elderly subjects, with or without albuminuria, with or without interstitial nephritis, is always the same. It recurs after a variable lapse of time, and the patient may succumb in the course of the attack, or he may die suddenly before the attack has had time to develop. The attack of so-called uræmic asthma presents all the symptoms, and runs the course of aortic or coronarial asthma.

It is conceivable that other vessels given off by the aorta and innervated by the pneumogastric, when affected with atheroma or endarteritis, may give rise to radiations in the direction of the bulbar respiratory centre, and so create the pathogenic reflex of asthma.

With asthma I generally associate the so-called renal acute œdema of the lung. This œdema also occurs in attacks: sudden onset accompanied by anxious oppression, but forthwith associated with a paroxysmal cough and copious sero-albuminous expectoration, as much as three or four pints in the course of a few hours, accompanied by lots of fine, subcrepitant, mucous, sibilant râles. Death may rapidly close the scene from asphyxia due to flooding of the bronchi by the exudation. Or in from half an hour to several hours the expectoration ceases, the dyspnœa subsides, and the attack undergoes complete resolution. Sometimes, however, the dyspnœa continues on and off for several days as the result of the bronchial "inundation." When the symptoms have subsided a variable interval of quiescence separates it from the next attack.

Just as with asthma, acute œdema does not supervene in cases of parenchymatous nephritis, in which we get anasarca, but as a consequence of interstitial nephritis, when there may be no œdema elsewhere, but where there is polyuria. It is also met with in association with aortitis and coronaritis, without nephritis or cardiac hypertrophy. Its mechanism appears to me to be that of aortic asthma, of which it would merely be one variety, characterized by the predominance of the nervous reflex on vaso-motor and secretory innervation of the bronchi, whence bronchial hypersecretion and dyspnœa.

Is Cheyne-Stokes breathing a uræmic dyspnœa, as has been generally admitted in France since Cuffer's thesis in 1878?

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P.—4

For my part I do not think it is the consequence of toxæmia. We meet with it, it is true, in nephritis, just as we do the so-called uræmic asthma, but, like the latter, only in interstitial nephritis, with cardiac hypertrophy and arterio-sclerosis. It may supervene when there is polyuria and a normal excretion of urea, it may even persist for weeks without any symptoms of urinary toxæmia. It is not peculiar to nephritis, it is met with in cardiac and aortic affections apart from nephritis, in cerebral hæmorrhage, in basic meningitis, and in presence of tumors of the encephalon. It is determined by ischæmia of the bulbar respiratory centre, whether this be the result of compression by cerebral hæmorrhage or a tumor or meningitic exudations, or as the result of bulbar enteritis, giving rise to thrombosis or embolism of the vessels. In all these conditions the ischæmia diminishes the excitability of the respiratory centre, and as the physiological stimulus is carbonic acid it requires a larger proportion in the blood to set it going, whence respiratory pause until a sufficient quantity has accumulated in the blood, and this, acting on the bulbar centre, excites the play of the respiratory muscles. It is, in truth, an intermittent "limp" of this centre. When, therefore, this phenomenon occurs in interstitial nephritis, it is due to concomitant arterio-sclerosis and ischæmia of the respiratory centre, and it is in no sense a manifestation of uræmia.

To sum up, in parenchymatous nephritis we get dyspnœa as the result of generalized œdema, with hydrothorax or acute pulmonary œdema, or when there is hydaræmia and chlorurræmia; in interstitial nephritis we meet with interference with respiration consequent upon cardiac hypertrophy, dyspnœa from asystole due to this hypertrophy, attacks of aortic or coronarial asthma, or with or without acute pulmonary œdema, and dyspnœa in the Cheyne-Stokes form. These are the various kinds of dyspnœa and their mechanisms met with in Bright's disease.

I am quite aware that uræmia may be super-added to these different mechanisms, but if the presence of these mechanisms does not exclude the possible concomitance of uræmia, the integrity of the lung and the normal working of the heart at the time of the onset of the dyspnœa on the other hand does not *per se* justify the diagnosis of uræmic dyspnœa. For this question to be raised there must be a reduction in the proportion of urea and a diminished secretion of urine with asotæmia. —*Medical Press.*

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# Miscellaneous

### The Treatment of Gastric Hyperacidity and Hypersecretion.

Boos, in the *Boston Medical and Surgical Journal,* states that the dietary directions for hyperacidity and hypersecretion are the same whether the cause is external or neurogenic. The patient's food should be carefully indicated by a list. In order that his stomach be never quite empty, he should have five or six meals a day, instead of three. He must take sufficient time to eat his meals, and he should rest after each main meal. On account of the possibility of hypermotility, the food should contain plenty of butter, which retards the emptying of the stomach. To reduce the supply of hydrochloric-acid-forming material, his diet should be made as nearly salt-free as possible. Sweets stimulate the flow of HCl, therefore they should be prohibited. As regards the diet list, Boos finds that his results are more satisfactory if he enumerates the things the patient may or may not have at each meal, rather than to indicate in a general way what he may eat and what he must avoid. The following is a sample:

Breakfast, 7.30 a.m.—Baked apple with cream; eggs, boiled, poached, on toast, shirred or scrambled; grilled bacon; steak or chop; Bensdorp's cocoa; occasionally one cup of coffee with much milk; buttered toast or crisp rolls.

10 a.m.—A glass of good, rich milk with bread and butter or zwieback.

Luncheon, 1 p.m.—Boiled rice or farina with cream or milk; a cup of custard, or milk toast; crackers with milk; green vegetables with mashed or baked potatoes; macaroni cooked with cheese; spaghetti; broiled, creamed, baked or boiled fish (no mackerel, salmon, or bluefish); occasionally cold meats; potatoes baked in their jackets with Parmesan cheese; fish chowder; oyster stew. With any of these luncheon dishes, bread and butter or buttered toast. Daily, baked apple with cream, stewed prunes or apricots, apple sauce.

4 p.m.—A glass of good, rich milk with bread and butter or zwieback.

Dinner, 6.30 p.m.—Oysters on the half-shell, from November 1st to March 31st, only; chowders (except clam chowder). Fish: As at luncheon. Meat: Fowl, game, veal, beef (rare), steak (rare), lamb, very mild ham. The meats should be pre-

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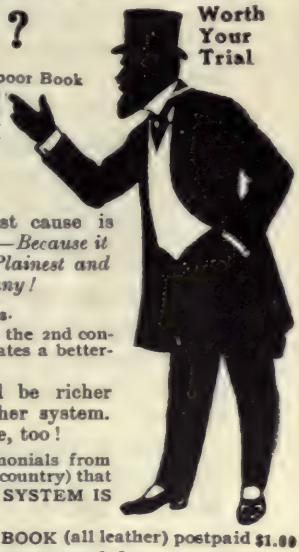

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pared in simple style, without fancy sauces and without spices. They should be roasted, broiled, stewed, pot roasted. Tender boiled beef and fowl are allowable. Vegetables: Young carrots, peas, beans, cauliflower, mashed turnips, asparagus tips, squash, summer squash, spinach in French style, lettuce, cooked like the spinach (very delicate), egg plant (not fried), oyster plant (not fried). Vegetables should be cooked with plenty of butter. When fresh vegetables are not available, the good brands of canned vegetables form a perfect substitute. Potatoes: Baked, boiled, au gratin, mashed or creamed. Macaroni rice, spaghetti, noodles. Green salads with plenty of oil and little vinegar. Weak tea. Soft crackers and a little mild cheese. Puddings are allowed, except plum, suet, steamed, or any other heavy puddings. Fruit and wine jellies are allowed; also ice cream, but it must be eaten very slowly, melting it in the mouth. No pies, pastry, or fritters.

9 p.m.—A glass of good, rich milk.

In general—No raw or fried onions, no radishes, garlic, horseradish, ketchup, chutney, Worcestershire sauce, pickles, curry, olives, mustard. Avoid hot or fresh bread. Do not eat fried or salty food, but use just enough salt in the food to make it palatable, no more. Little or no sugar in the food. No candy. Rest for half an hour or longer after each main meal of the day, lying on the right side. Take regular exercise, such as walking, swimming, doubles in tennis, golf, horseback riding, bowling (in winter).

Eat slowly. Chew the food well. Go to bed early. Do not read novels at night. Stop worrying. Keep the bowels regular. Take a tepid sponge bath in the morning.

Milk is given between meals because the proteids in it absorb much pepsin-hydrochloric acid, while the butter-fat delays emptying of the stomach. The use of some alkaline water at meals or immediately after is advisable in all cases, and French Vichy is good for this purpose. A glass of Vichy or simply of hot water on an empty stomach also helps to relieve the morning distress of hypersecretion by diluting the acid contents of the stomach.

This dietary regimen is suitable also for cases of gastric ulcer with hyperacidity, but ulcer patients must be warned to avoid, in addition, foods leaving a coarse residue, such as cabbage and most greens, as also raw fruit like apples, pears, pineapple, etc., and nuts and raisins.

# TROUBLE AHEAD

Acute catarrhal inflammations of the upper air passages — coryza, rhinitis, etc., while usually independent affections, frequently indicate serious trouble ahead. Pneumonia, la grippe, bronchitis and other diseases of the respiratory tract, generally have the premonitory head and nose symptoms popularly called "Cold in the head."

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applied hot over the entire naso-malar regions, reduces the swelling of the mucous membrane of the septum and lower turbinated bodies; lessens the irritating excretions; dispels the "stuffed up" feeling, and relieves the pain over the frontal sinuses. Antiphlogistine combats the invasion of bacteria by increasing the activity of the blood, stimulating leucocytosis, and encouraging the production of anti-bodies.

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As Boos has stated, many cases of hyperacidity, due merely to external causes, will gradually yield to the regimen alone, but improvement is, of course, more rapid if the patient receives medicine from the start. Hyperacidity of neurogenic origin always requires medicines.

In the medicinal treatment of hyperacidity, preparations containing proteolytic ferments, such as pepsin, papain, and pancreatin, have been much in vogue. The use of these ferments is, to his mind, however, quite irrational, since in cases of this kind the pepsin is already present in abnormal amount. The gastric juice of the patient with hyperacidity contains not simply excessive hydrochloric acid, but excessive pepsin-hydrochloric acid; in other words, the pepsin is increased in the same measure as the hydrochloric acid, with the result that digestion is really more vigorous than in the normal individual. What these patients need is neutralization of the acid, with consequent relief from its irritant action on the gastric mucous membrane. Bicarbonate of soda gives this relief very promptly, but its neutralizing effect does not last long, since this salt, being soluble, is carried out of the stomach by peristalsis before the excessive acid formation has ceased. In order to obtain more lasting neutralization, it is necessary to use insoluble compounds, such as carbonates of magnesia and lime, and the oxides of magnesium. These substances are precipitated among the rugæ of the gastric mucous membrane, where they remain to neutralize the hydrochloric acid as it is formed. They are removed from the stomach only as they are converted into their soluble chlorides. Boos finds that in nervous hyperacidity with a tendency to loose bowels, carbonate of lime develops a threefold action; it neutralizes the excess of acid, it stops the looseness of the bowels, and the absorption into the system of the calcium chloride which is formed in the stomach produces a distinct quieting effect on the patient's nervous condition.—*The Therapeutic Gazette.*

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**Tonsil Operation**

Voorhees, in his interesting article in the *N. Y. State Jour. of Med.* (Mar., 1917), says in conclusion:

1. An analysis of tonsil operations in singers shows that in the hands of skilled operators there need be no special fear of bad results.

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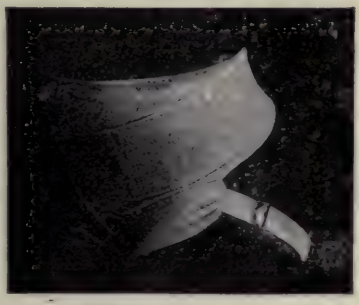

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2. It is the concensus of opinion that bad results are most often due to cicatricial contractions occurring from careless dissection or from neglected after-treatment.

3. Pain in the tonsillar region, neck and larynx, is probably due to section of some of the larger branches of the glossopharyngeal nerve (Justus Matthews).

4. Loss of singing voice occurs very rarely after tonsillectomy, if at all. Impaired voice is possible, but most cases show an increased range of from one-half to a full tone.

5. Loss of singing voice after tonsillectomy might be due to a nerve lesion, but is probably due to adhesions and cicatricial formations in the fauces.

6. The singer's problem is a very special one, and no laryngologist should undertake to operate on these patients unless he has some knowledge of the art of singing.

7. At operation the greatest care and skill must be exercised in securing a clean, free dissection. Injury to the tissues surrounding the tonsil may prove disastrous.

8. Postoperative care is of special importance. The patient should be seen daily until full healing ensues.

---

**Twilight Sleep**

To *Medicine and Surgery* for August, 1917, Dorland contributes an article, in the course of which he has this to say of twilight sleep:

The desire to alleviate the suffering of parturition, at least to an appreciable degree, is universal, and various suggestions along this line have been made from time to time. About fifteen years ago a pretentious move in this direction advocated the use of narcotics to deaden the pains of labor. Not only abroad, but in this country as well, this suggestion was thoroughly tested, only to be reluctantly abandoned because of the serious and even fatal results both to mother and child which followed in many cases. A few years ago the method was revived with certain improvements, and having been adopted by the Freiburg Clinic, it was widely exploited in Germany and France, and more recently here under the absurd name, "twilight sleep." Enthusiastic followers of the scopolamine-morphine method sprang up as if by magic all over the country, and extravagant claims were circulated to prove its excellence and superiority over similar methods in vogue.

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In the meantime the maternity departments of many reliable hospitals instituted a careful scientific study of the method, some in selected cases and others generally in their maternity work. From these studies there slowly accumulated sufficient accurate data to prove conclusively that the method was fraught with such dangers for both mother and child as to render its further use unwarranted. The Johns Hopkins Hospital of Baltimore, the Mt. Sinai Hospital of New York, the Michael Reese Hospital of Chicago, and other large and reputable maternity hospitals issued authentic reports containing warnings to the profession and general public and condemning the method unqualifiedly. However, notwithstanding the wide publication of these condemnations, certain physicians have continued the use of the method, and by every means within their power, legitimate and otherwise, have let the public know that they are engaged in this work.

In the face of honest protestations from the reputable obstetricians of the country, who would gladly indorse and support any safe means of relieving the pangs of childbirth, such persistence must be regarded as unethical and done for one purpose only. It is an exploitation for commercial reasons—for the profit that is in it. Thousands of women, not knowing the risks that they and their offspring are running, eagerly submit to the method which is advertised by these unscrupulous physicians and which is proclaimed broadcast by equally unscrupulous and vastly more dangerous periodicals that publish beautifully written and alluring descriptions of the wonderful boon conferred upon suffering womankind. It has even been stated that mankind generally, and male physicians especially, lack the proper sympathy for women in childbirth, or they would adopt any measures which might be proposed for their relief. This untruth is most invidious and unkind. No more whole-hearted, sympathetic and devoted group of men can be found than those in the medical profession. Their reluctant abandonment of the scopolamine-morphine treatment because of its danger and their eager response to the nitrous oxide anæsthesia, as more recently advocated by eminent obstetricians in this country, prove their loyal devotion to the mothers of the land. "Safety first," however, is their ethical and honest stand; and in the strength of their position and with the support of recognized science behind them, they calmly face the shrewd and unethical advocates of unsafe and discarded methods while educating the public to a true understanding of the situation.—*Therapeutic Gazette.*

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### Poisoning by Acetyl-Salicylic Acid

W. Fletcher Stiell (*Practitioner*) reports the case of a lady, aged 50, who took 10 grains of aspirin twice daily for seven years for rheumatoid arthritis. She received great benefit from the drug; so much so, that even a slight diminution of dose unknown to the patient was at once followed by incapacity to perform voluntary movements. In the seventh year of treatment the first signs of poisoning appeared in the form of conjunctivitis, chemosis, and lachrymation. Discontinuance of the drug was impracticable owing to the relapse which followed. A week later the patient developed a typical urticaria major. There were also insomnia, diarrhœa, vomiting, œdema, of the tongue and fauces, and palpebral œdema obscuring the vision. Aspirin was withheld, and ichthyol, with liquor arsenicalis, belladonna, and calcium lactate, given. Since the onset of the urticaria, although all aspirin has been discontinued, all traces of rheumatism have been absent.—*The Prescriber.*

---

### Artificial Cerebrospinal Fluid

The following formula is recommended by McKenzie (*Jour. Laryngology, Rhinology, and Otology*) for lavage in epidemic meningitis:

| | |
|---|---|
| Potassium chloride | 3.5 |
| Sodium chloride | 1.5 |
| Potassium carbonate | 0.2 |
| Glucose | 2.0 |
| Distilled water | 100.0 |

This forms a stock solution, from which the fluid for use (sp. gr. 1.002) is made up as follows:

| | |
|---|---|
| Stock solution | 10 |
| Sterile distilled water | 90 |

In making the stock solution the salts should be dissolved in the water and the solution boiled before the glucose is added to it.—*The Prescriber.*

# The Canadian Practitioner and Review

Vol. XLIII. TORONTO, MAY, 1918 No. 5


## Original Communications

### THE CYSTOSCOPE, AN ESSENTIAL IN GENITO-URINARY SURGERY


COLIN LUKE BEGG, A.B., M.D.

Adjunct-Professor of Urology, New York: Post-Graduate Medical School and Hospital, New York City: Cystoscopist Columbus Hospital, New York City.


There is, perhaps, no branch of surgery in which greater advance has been made within the past quarter of a century than in that of the genito-urinary tract. Prior to this, the history, symptomatology, chemical and microscopical examinations of the urine were, in lieu of better means of diagnosis, relied upon mainly in surgical diseases of the hidden regions, from the urinary meatus to the kidney.

*History.*—Attempts to view the interior of the urethra and bladder were made as early as 1806. Bozzini, of Frankfort, in this year utilized a funnel-shaped speculum through which by the light from a candle he essayed to look into the female bladder. The reports were so disappointing that little was accomplished along this line until Desormeaux in 1855 presented before the Imperial Academy of Medicine in Paris his endoscope, through which an examination of the bladder was with difficulty possible in the female. To see beyond the urethral curve in the male was, of course, not even considered.

Steady advancement was made from this time until Brück, a dentist of Breslau, in 1867 devised an instrument, the stomatoscope, by which he illuminated the mouth by means of a platinum loop heated to white heat by the galvanic current. Utilizing the platinum loop idea, Dr. Max Nitze, in 1876, completed the first electric cystoscope embodying the principal factors of modern cystoscopy, viz., the light within the bladder,

the electric source of the light, and the use of the lens system. On account, however, of the difficulty of keeping the cystoscope cool by means of a constant stream of cold water within the instrument, and the frequent fusing of the platinum loop, the original models were complicated and proved unsatisfactory.

The discovery by Thomas Edison in 1880 of the incandescent lamp revolutionized the construction of illuminating instruments and paved the way for the manufacture of a practical cystoscope which did not require the services of a skilled electrician in its use. Step by step, marked improvements were made. Lieter, Boisseau de Rocher, Brenner, Caspar and Albarran in Europe, and Brown, Ayres, Bierhoff, and Buerger in America, each has added his modification until to-day we possess reliable cold lamp instruments by which even the general practitioner with some instruction and practice can obtain a perfect illumination of the urethra and entire bladder interior, and through which irrigation may be carried on during the cystoscopy; through which catheters may be passed to each kidney synchronously; through which treatment may be applied to the urethra, bladder, ureters, and kidney pelves; and through which operations of no small magnitude may be done within the urethra and bladder.

*Urethra.*—In the surgery and treatment of the anterior and posterior urethra, illuminating devices are absolutely essential. The incision of a peri-urethral abscess from within the urethra through an endoscopic tube, thereby often avoiding an urethral fistula, the treatment or destruction of infected mucous glands, the removal of papillomata or polypi by snare or fulgurating wire, the removal by forceps of an urethral stone or foreign body, the insertion of a filiform bougie into the opening of a tight fibrous stricture, the direct application of treatment to an hypertrophied veru montanum, are all cases showing how necessary it is to visually examine this portion of the genito-urinary tract.

*Bladder.*—At the bladder neck and within the bladder, cystoscopy has made of the surgery of this region an almost exact science, and it is the writer's opinion that no operation should be attempted on the prostate or bladder without a preliminary attempt to view the field. How often has suprapubic cystotomy been done for supposed hypertrophic prostate, and no enlargement of the prostate found to account for the obstruction? How frequently, too, has a perineal prostatectomy been found to bring about no relief of symptoms, because subse-

quent cystoscopic examination determined the obstructive cause to be a prostatic bar or hypertrophy of Albarran's glands? How many cases having all the classic symptoms of prostatic hypertrophy have been judged to be free from prostatism because by rectal palpation the gland appeared as small or smaller than normal, when in reality marked protrusion of the middle lobe into the bladder prevented the emptying of the viscus? Cases are not infrequently sent to our hospitals in which on account of the patient's age a diagnosis of prostatic obstruction has been made, when there was really a stricture at the bulbo-membranous junction; and *vice versa*, cases of early prostatic hypertrophy have been diagnosed as stricture. The frequency of micturition, the slow, small, feeble stream, and the residual urine in those suffering from ataxic bladder or atonic bladder from other spinal lesions, often lead to error in diagnosis, which a cystoscopic view of the bladder wall and neck would readily make clear.

Sacculations and diverticulæ of the bladder, which frequently require surgical intervention for their cure, are almost impossible of diagnosis, and often not even suspected, unless the cystoscope detects their presence. Their size and location will decide for the surgeon whether they are amenable to surgical treatment. As an aid to such determination, the filling of the bladder with radiographically opaque solutions, such as thorium or collargol, is of great assistance. In those rather rare cases of vesical fistulæ leading to neighboring body cavities, cystoscopy is indispensable to the surgeon.

Symptoms and the stone searcher have made known the presence of vesical calculus for centuries, and their size could be determined with fair accuracy. The number present and their composition were more difficult problems to solve, and in cases of encysted stone the diagnosis was usually faulty. The click of the searcher on a phosphatic deposit on the bladder wall could also easily be mistaken for calculus. To-day the number, size and freedom in the bladder cavity, are accurately determined prior to operation and, if the knife has been decided upon, whether the stone is best delivered by the perineal or suprapubic route or perchance, with small calculus, by forceps through an operating cystoscope.

By the color and general appearance we are usually able to tell the density of the stone, and it is the opinion of the writer that, given a sufficiently capacious urethra and a stone of not too great hardness or size, litholopaxy is the operation of choice.

When one considers that the death rate for litholopaxy is approximately 2.4 per cent., while that for lithotomy is from 10 to 13 per cent., the crushing operation with its infinitely lower mortality, with all chances of fistulæ obviated, with the danger from general anæsthesia eliminated, not to mention the debilitating sojourn in the hospital bed, litholopaxy should be utilized more frequently than it is. The writer calls to mind two cases, one a man of fifty with marked pulmonary tuberculosis, to whom it was inadvisable to give a general anæsthetic and who remained in the hospital for only forty-eight hours after the crushing and removal of a large calculus; the other, a man in the out-patient department who could not leave the work which enabled his large family to live and for whom a urate calculus as big as an egg was crushed and evacuated in the clinic at two sittings, the patient returning home immediately and going to work the next morning. By whichever method, post-operative cystoscopy is essential, to be sure that the last particle has been removed or that a small stone has not been left to form the nucleus of another calculus.

It is worthy to note, too, the extreme simplicity of removing through the cystoscope foreign bodies, such as hairpins, ligatures, pieces of catheters, etc., which have found their way into the bladder.

The method of making a diagnosis of bladder tumors has undergone marked change since the introduction of the cystoscope. It is but a few years since the cause of hæmaturia and the location from which the bleeding came, was largely a matter of guesswork, and an exploratory operation was usually needed to clear up the diagnosis. Quoting from Keyes' Genito-Urinary Surgery, published in 1890: "The blood usually comes from the urethra, bladder, or kidney, and it is often of the utmost importance to decide from which of these three sources it is derived. There are but few distinguishing marks." Thanks to cystoscopy, exploratory operations to decide the source or cause of hæmorrhage in the genito-urinary tract are now the marked exception rather than the rule. Not only is it usually easy to determine whether the bleeding comes from the urethra but also to find the lesion causing it. If from the bladder, be it benign or malignant tumor, or calculus, or ulceration due to severe cystitis or tuberculosis, a diagnosis is readily made.

By utilizing accessory instruments through the operating cystoscope, viz., snare, punch forceps, scissors, etc., portions of

growths or pathologic tissues are obtained for microscopic examination, thus rendering to the surgeon aid of untold value.

In the treatment of bladder tumors, the advance has been exceptionally phenomenal since the planning and carrying into effect of the utilization through the cystoscope of fulguration by the Oudin or d'Arsonval currents, as advocated by Dr. Edwin Beer, of New York, in 1910. This method of treating vesical neoplasms has been extremely gratifying in the light of discouraging results by both operative and non-operative methods in days agone. The frequency of relapses, even in those tumors which appeared benign clinically and were pronounced non-malignant by laboratory examination, caused the careful surgeon to hesitate in making a good prognosis. In all cases of benign vesical growths (papillomata and polypi) a cure can be promised and this, too, without pain except that incident to the passing of the instrument, without detention in a hospital, and without the danger and discomfort of general anæsthesia.

The difficulties encountered in doing this work are (1) severe cystitis with tenesmus, in which case it is sometimes difficult to obtain a good view, owing to small bladder capacity or to the inserted fluid becoming quickly clouded; or (2) hæmorrhages so marked as to almost immediately obscure the vision. With the modern irrigating cystoscope, however, the former is usually overcome, and in the latter case the bleeding points can generally be detected and fulgurated so that on the second treatment a clear field is obtained. In from one to five or six sittings at intervals of four to seven days, depending on its size, the growth is eradicated. In one of the author's cases it took nine fulgurations to remove a papilloma the size of an egg. Three years later, cystoscopic examination failed to reveal any return.

In his earlier writings, Beer expressed hopes of curing carcinoma in the early stage, but his later observations and those of practically all others, would indicate that a cure of malignant growths cannot be expected by this means. The proper procedure in such cases would seem to be wide bladder resection where possible. In inoperable cases, however, the bleeding can be checked, the growth decreased in size, and the patient made more comfortable by the high frequency current.

Another utilization of this current which has been accompanied with some success applies to those extremely difficult cases of obstruction to the outflow of urine due to contracted bladder neck or to a prostatic bar without prostatic enlargement.

A furrow is burned through the obstruction in the middle line, on successive occasions, until it is deep enough to permit the complete emptying of the bladder on urination.

While primary bladder tuberculosis is possible, its occurrence is undoubtedly very rare. It is found usually as an extension from the prostate or seminal vesicle, or as a descending infection from the kidney. Where one has found on rectal examination that tuberculosis does exist in the prostate or adnexa and there is evidence of an extension to the bladder, cystoscopy is contra-indicated, as favoring, by trauma or mixed infection, the increase of the cystitis. Where, however, tubercle bacilli have been found in the urine and no nodules are to be detected in the neighboring genital organs, the possibility of single or double kidney tuberculosis, as the forerunner of the bladder condition, is very great. The ulceration, the bullous œdema, the irregular distortion, the infiltration, or the retraction of one or both ureteral orifices, gives a picture which goes far toward making the diagnosis plain, even without catheterizing the ureters.

Brilliant as have been the results in diagnosis and treatment attained by the use of the cystoscope in the lower urinary tract, it is in the surgery of the upper part, the ureter, kidney pelvis, and kidney cystoscopy is most essential. Especially is this true when used in conjunction with radiography.

*Ureter.*—Not infrequently from subacute or chronic inflammation (tuberculous or gonorrhœal) or from the passage or impaction of a calculus, the lumen of the ureter may be lessened at one or more points. These strictures, if allowed to persist, may mean the ultimate destruction of the kidney above. If the stricture is at the bladder orifice, due to contraction from intravesical pathologic process, it may be enlarged by scissors through the operating cystoscope. In cicatricial contractions further up the ureter, flexible bougies of increasing sizes are fully passed through the obstruction till its lumen is restored.

When a ureteral calculus is suspected, the radiograph is used to confirm our suspicions. At times the plates are not satisfactory, and sometimes a uric acid concretion does not throw a good shadow. In such cases, the scratches on a wax-tipped catheter will clear up the diagnosis.

Much can be done, too, cystoscopically, to assist the passage of a stone rather than by performing a hurried ureterotomy for its removal or by waiting for nature, assisted by morphine and hot applications, to expel it. Dilating the ureter by bougies

or by passing a ureteral catheter, which from a small end gradually increases in size, as far as the stone, and then carefully injecting sterile oil through the catheter, to slightly distend the ureter below the calculus and at the same time lubricate the passage, has, on a number of occasions in the author's practice, been followed by expulsion of the calculus.

The case of H. Fortunato is one of such. He came to the clinic on May 24, 1914, giving a history of having had a number of typical attacks of kidney colic during the week past. A radiograph showed a small shadow resembling calculus in the location of the ureter in its lower third. A ureteral catheter was obstructed at the point where the shadow occurred. On the next clinic day—two days later—he stated that he had had another attack of colic. The procedure with the catheter and oil, as outlined, was used, with the result that the same evening he passed the small stone.

The shadows on the radiographic plate produced by phleboliths or calcified glands, when there happen to be such in the immediate proximity of the ureter, are apt to be misleading. In such cases, taking another x-ray with an opaque catheter in the ureter will overcome the difficulty.

It might not be out of place here to mention how frequently in certain operations on the pelvis and abdomen, the ureter, on one side or the other, has been inadvertently cut through or torn. The passage of a ureteral catheter prior to operation is likely to obviate this mishap.

*Kidney.*—He who attempts to perform kidney surgery without having first employed cystoscopic aid is doomed to meet with many failures. A patient may present striking ocular, palpebral, and microscopic evidence of one diseased kidney which needs surgical attention. On exposure, the kidney is found to be in such a condition as to warrant removal. Would it not have been well to have determined beforehand if the patient had a second kidney? Or, if he was fortunate enough to possess a second kidney, was this kidney as bad as the first? Mathematically speaking, one diseased kidney is better than no kidney; and two diseased kidneys will carry on the excretory function better than one diseased kidney.

Cystoscopy and ureteral catheterization, with the radiograph as an adjunct, can determine for us with almost absolute certainty:

I. Whether there are two kidneys; if only one, which one is absent.

II. Whether the kidneys are in their proper respective positions, or whether movable or floating.

III. When there is hæmaturia not having its origin in the urethra or bladder—whether it comes from one kidney or both; and if from only one side, from which side. In the same way, not only the origin of pus from the kidneys, but the bacteria (tubercle bacillus, bacillis coli communis, etc.) causing it, are determined.

IV. Whether the capacity of each kidney pelvis is normal, i.e., whether we are dealing with a pyelitis, pyonephrosis, hydronephrosis, or a large pus sac with little or no functionating kidney tissue remaining.

V. The functionating power of each kidney separately and relatively is also readily determined—not only by the determination of the specific gravity, total solids, urea, etc., but also by utilizing the knowledge that certain substances injected into the blood stream or tissues will be eliminated and appear in the urine, from normal kidneys, in a known time and in known amount. The time of appearance is delayed and the total amount excreted in a given time lessened, in diseased kidney conditions. Many substances have been used for this purpose—methylene blue, potassium iodide, indigo carmine, phloridzin, etc., but more recently phenolsulphonephthalein has been considered by those who have used it extensively to be the most accurate test to determine the functional activity of the kidney.

VI. When there is disease present, ureteral catheterization will determine whether both kidneys are affected or only one, and if only one, which is the one affected; if both kidneys are affected, which is the worse; and if it is thought advisable to remove the more damaged kidney, whether the other will functionate sufficiently to carry on life.

In conclusion, the writer believes that (*a*) without cystoscopic aid urologic diagnosis is frequently faulty and ofttimes impossible; (*b*) that certain operative procedures can be performed through the cystoscope which otherwise would require a cutting operation; (3) that therefore cystoscopic technique should be more universally studied and employed.

131 East 17th Street, New York City.

# Editorials

## THE CARE OF YOUNG BABES

The Chief Officer of Health of Ontario has given a partial report of an interview he recently had with Dr. F. Truby King, of New Zealand, who had stopped in Toronto for a short time on his journey to England. Among other things he told something about the work of the Society for the Health of Women and Children, which was organized in 1907. The object of the Society was to do educational work regarding the care of young babes. He illustrated the value of the work done, by giving certain figures. For some years before 1907, the average death rate among children in one year was eighty per thousand births. Last year the rate was fifty per thousand births. We can learn something as to what this means by considering the rates in other places: London, England, 101; Paris, France, 120; Massachusetts, 131; Ontario, 102; Montreal, 210; Petrograd, 280.

Dr. King says the results in New Zealand are due largely to the work of the Society. The main work is carried on by nurses, of whom there are twenty-two. Their chief aim is to educate parents and others in the hygiene of the home and nursing. The nurse works within a radius of fifty miles in different communities and organizes local committees, who carry on her work at intervals between her visits. The nurse visits schools where she gives demonstrations, often using a live babe for the purpose, attends

mothers' meetings and visits homes. She visits the homes of the poor and also those of the well-to-do, who, Dr. King says, are often the most badly informed as to the care of the babes.

## THE HAMILTON MEDICAL WEEK

Our good, generous friends of Hamilton, with the sympathetic help of many outside of that city, are endeavoring to make the coming Medical Congress a decided success. The good wishes of the profession in all parts of the Dominion go with them in their heavy task of combining five different societies in one large meeting, which will be held May 27th to June 1st. An attempt is being made, so far as possible, to include within five days the proceedings which, under ordinary conditions, should occupy twelve or thirteen days.

The latest reports from the Local Committee inform us that the various difficulties that arose from time to time have been overcome, and the prospects for a very interesting and successful meeting are now very bright. The following is taken from the Provisional Programme, issued April 13th: Monday and Tuesday, a joint meeting of the Canadian Public Health and the Ontario Health Officers' Associations; two Presidential addresses, W. H. Hattie, Halifax; H. W. Hill, London; Papers from J. A. Boudouin, Lachine, Que.; M. M. Seymour, Regina; J. J. Harper, Alliston; Grace Meigs, Washington, D.C.; Richard Bolt, Cleveland, O.; J. W. S. McCullough, W. C. Alliston, Frederick Paul, Charles J. Hastings, Gordon Bates, F. A. Dallyn, H. M. Lancaster,

C. E. Hincks, C. F. Boldman, Alan Brown, George Smith and Mary Power, of Toronto.

Wednesday: Tuberculosis Association. Address of welcome, J. P. Morton, Hamilton. President's address, J. A. Machado, Ottawa; Geo. Porter, H. W. Hill, J. S. Pritchers, Battle Creek, Mich.; A. F. Miller, Kentville, N.S.; C. D. Parfitt, Gravenhurst; J. H. Prayer, Buffalo, and J. H. Elliott, Toronto.

8.15 p.m.—Combined General Session; Presidential address, C.M.A., Beaumont Small, Ottawa; Collin Russell, I. H. Cameron and Hadley Williams.

Thursday—C.M.A. and O.M.A.

9 a.m.—Meetings in Sections.

2 p.m.—General Session: Addresses—Obstetrics, J. DeLee, Chicago; Pediatrics, Isaac Abt, Chicago; Medicine, L. F. Barker, Baltimore.

7.30 p.m.—General Session: Address on The Ear, Isaac Jones, Philadelphia.

Friday:

9 a.m.—Meetings in Sections.

2 p.m.—General Session: W. F. Hamilton, and A. E. Garrow, Montreal; J. R. McLeod, Cleveland.

7.30 p.m.—General Session: Charles H. Mayo, Rochester, Minn.; Frank Billings, Chicago.

Members are requested to send for their reservation at once.

Look for the Green Cross and use it often.

Appear in informal dress on all occasions.

Final programmes will be sent to all who make application.

Drs. Charles Mayo and Frank Billings will conduct medical and surgical clinics on Saturday.

On account of war conditions, the usual banquet will not be held. In place of this, four informal din-

ners will be served in the large assembly hall at 6.30 p.m., Monday, Tuesday, Thursday and Friday. Wednesday afternoon a trip to the Mountain Sanitarium, where high tea will be served. Friday evening, smoking concert. Saturday at one o'clock, luncheon at the new hospital, provided by the Board of Governors of the City Hospitals.

Efforts were made to get reduced railway rates, but according to the latest report the usual convention railway rates have been cancelled for this year.

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## THE SPREAD OF SCARLET FEVER

We hoped the time had come in a city like Toronto when the importance of preventing the spread of serious disease was duly appreciated, at least by those in authority, but we were mistaken. One of our controllers, Mr. McBride, thinks it wrong to confine a Mrs. Tozer in her home because members of the Health Department say there is scarlet fever in the house. He thinks she should be allowed to go about and spread the disease broadcast rather than suffer the inconvenience of quarantine. In connection therewith we were sorry to learn that John O'Neill, one of the best controllers Toronto has known, said such reports were greatly exaggerated, because that conveys an entirely wrong impression, namely, that the reports are partially true, while, as a matter of fact, they are definite falsehoods, and dangerous ones too. Let us relate briefly an incident which occurred at the very time that Controller McBride was searching for evidence against the health authorities. A prominent physician in the United States,

known to many in Toronto, Dr. Dunn, had an only child, aged nineteen, described by a friend in Toronto as a charming, splendid boy. He enlisted last year, joining the Aviation Corps. He came to Toronto to train, and unfortunately contracted scarlet fever. After hearing of this by telegram, father, mother, and a maiden aunt rushed to Toronto, and reached the Base Hospital a few hours before the boy died. Other brave boys were sick. Five young soldiers died within a short time (about four weeks). During the same weeks there were eight deaths among civilians. The health doctors were horrified, and united in a very vigorous effort to stop the spread of the disease, while in the city hall, Controller McBride raved and shouted "Don't dare to interfere with my friend, Mrs. Tozer."

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## THE HALIFAX DISASTER

The official Medical Report of this disaster teaches us that there was no exaggeration in the tidings first received regarding the same. About 9 a.m., December 6th, 1917, the city of Halifax was startled by a loud report, followed immediately by a trembling of the earth, as from an earthquake. A few seconds later a tremendous explosion was heard, vast clouds of smoke and flame shot into the air, and the north end of the city (about 1¼ miles square) was laid in ruins.

The explosion was caused by fire on the French ammunition ship *Mount Blanc*, which had been rammed by the Belgian ship *Imo*. Hundreds of fires broke out and added to the horrors of the disaster.

As nearly as can be estimated, 1,500 people were killed, and 5,000 injured (1,000 seriously).

We have, in former issues, given some particulars as to the methods adopted, especially for the care of the wounded. We are glad to learn from this report that the relief methods adopted were admirable beyond words.

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## THE WAR STRAIN ON GENERALS

This war has developed new ailments, especially of the neurotic type. We have returned soldiers untouched by bullet or shell, who are said to be suffering from "shell shock." No one appears to be able now to define exactly what shell shock means, and perhaps a more fitting term will soon come into use. Few of the leading generals in any of the countries at war appear to last long. So far as we know at present Hindenburg appears to have done more work than any other general on either side has accomplished. Many changes have occurred in the higher ranks of the allied armies. The recent retirement of that brave and accomplished soldier, General Gough, commander of the Fifth British army, has caused much comment, and great sorrow in certain quarters. It is suspected by some that his physical condition was impaired by the terrific strain of war. Certainly many others have broken down, although we know but few particulars in most cases. Rumor told us a long time ago, that that brave and skillful general, Sir Horace L. Smith-Dorrien, had broken down. We were told at another time that Sir John French was simply worn out by the tremendous re-

sponsibility placed upon him. Rumor also says that Sir Ian Hamilton at Gallipoli, Sir John Nixon and Sir Archibald Murray, all broke down at critical times. One military critic in England said, " So revolutionary are the present methods of warfare, so terrific the pressure on generals, that a man requires a year to learn his task, and that in another year his task has worn him out."

## THE HUN AND THE WOUNDED SOLDIER

The Hun has certainly developed to a wonderful degree two new traits in this war; the first being his delight at his " frightfulness " in murdering defenceless women and children. From his point of view the work of the new gun with a range of over seventy miles has been a wonderful success. The German mind was filled with profound pleasure when news came that a shell had destroyed a church and killed a number of people, including women and children while at worship on Easter Sunday. The next custom of the Huns which prevails to such a considerable extent at present, is the shelling of hospitals and hospital ships, which, as Colonel MacKendrick told the Empire Club of Toronto recently, was regularly, systematically, intentionally and continuously carried on by the Germans. Among the hospitals shelled recently in the Somme region were the Canadians, Nos. 2 and 3, which had stayed in that region for over two years, and of which the Germans had the exact range.

One of our Toronto soldiers severely wounded at the battle of Vimy Ridge was removed to England

two weeks after the battle. A severe wound through the chest made him perfectly helpless for the time being, lying on his back. On the first night of his journey he was placed on a hospital ship which lay all night in the harbor at Calais. During the night the Germans tried to shell the ship. Our soldier's account of his sensations was interesting; although he is really one of the bravest of the brave, he acknowledged that he was in a " terrible funk " while those shells were whizzing over his head and dropping in the water beside him. Fortunately the ship was not touched, and our soldier felt inexpressibly relieved when they ceased firing. He said it was bad enough to have shells and bullets whizzing round you when you were in action, but to have the things whizzing over and around you while lying flat on your back was still more undesirable.

# News Items

We are told that 505 medical men, combatants, in the British army had been killed or died of wounds up to the close of 1917.

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An English medical journal tells us that Red Cross nurses to the number of 200 were sumptuously entertained at Bristol by the ladies committee of the Colonial Institute. Queen Alexandra sent a message expressing her pleasure. "That Bristol is doing honor to the nurses whose splendid work is so deeply appreciated throughout the Empire."

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It was announced early in April that Col. Chas. Hodgetts, C.M.G., had resigned from his position as Red Cross Commissioner. We do not know the exact reasons, but a cable message received April 4th stated that he was dissatisfied with the management of the Red Cross Society in England. We believe that he now has charge of important work in connection with the C.A.M.C.

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The Women of England are raising a memorial to the late Dr. Elizabeth Garrett Anderson, which will take the form of an endowment of beds for the Hospital for Women, Euston Road, which was founded in 1866. A committee of women in Edinburgh are raising a memorial to the late Dr. Elsie Ingles. It will take the form of an enlargement to the Hospice in Edinburgh, which was established in 1899, and an endowment for the instruction of women medical students.

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The London *Chronicle* relates a few instances which illustrate some of Germany's food troubles. In 1917 40,000 half-starved children were sent from Hamburg into the country to recuperate. Recently a ham weighing 15 pounds was sold in Hamburg for $237. The butter consignments of Hanover in February were so small that as a substitute two oz. of edible fat were given. There is an epidemic of hunger typhus in Hanover and South Germany. In Blentheim tea costs $7.50 a pound.

In the German drive which commenced March 21st, certain medical stations were occupied by the enemy. We are told that up to April 10th surgeons and nurses were safely evacuated. In certain cases the equipment, or a goodly portion of it, was lost, but fortunately was soon replaced. We are told that in many instances Canadian and Australian surgeons and nurses have rendered very valuable service to the British wounded.

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At a meeting of the Hospital Trust; London, Ont., March 19th, Dr. F. W. Luny, of the Institute of Public Health, was appointed pathologist for the Victoria Hospital. Dr. W. F. Hodgetts was placed on the active staff in the place of Dr. E. Young, who has gone to Byron Sanitarium, and Dr. J. E. McClarty in the place of Dr. Freel, who has gone overseas.

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We regret to announce that Dr. Alf. Thompson, the competent Superintendent of the Hospitals for Returned Soldier Invalids, resigned April 1. We understand he was compelled to do this because, being M.P. for the Yukon, the "Independence of Parliament Act" prevented him from being an officer in a purely civilian organization, which the Invalid Soldiers' Commission has become by the recent act of Parliament.

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At the last session of the Ontario Parliament, Dr. Forbes Godfrey, M.P.P. for West York, introduced a Bill to amend the Marriage Act, which proposed to make both contracting parties to a marriage produce medical certificates of good health and sanity, but withdrew the bill with the understanding that the matter would receive consideration in the near future. Similar laws have been enacted in certain of the Western States, but without any special results up to the present time, so far as we can learn.

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Col. W. B. Hendry, D.S.O., was very busy during the recent leave of absence of one month in Toronto. Certain changes were made as to the Staff of the University Hospital at Basingstoke, and consultations were held in regard to the building of additions which will mean greatly increased accommodation. Col. Hendry left Toronto for overseas, April 14th. It was under-

stood that Lieut-Col. Harold Parsons, who was in charge at Basingstoke during Col. Hendry's absence, would return to Canada, and become a member of the Hospitals Inspection Committee. Captain Wm. Goldie, C.A.M.C., left for England, April 16th. He was ordered to go to Basingstoke to take the place of Dr. Parsons.

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The following members of the C.A.M.C. have joined the R.A.M.C. as temporary lieutenants: Drs. B. S. Cornell, H. E. Thompson, F. E. Webb, A. B. Earle, C. H. Aylen, G. O. Grain, W. E. Brown, C. F. Williams, A. B. Cooke, D. G. Garrett, C. J. Miner, C.O. Miller, W. P. McCowan, F. H. Boone, F. Spearing, W. E. Martin, P. R. Shannon, S. Bardal, F. G. McGuinnes, T. G. Playford, A. M. Clare, R. C. McLaughlin, W. F. Tisdale, T. W. Shaw, H. M. Raphael, and R. R. MacGregor.

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*The Wittenberg Horror.*—More than two years ago we gave a somewhat detailed account of the typhus epidemic in the Wittenberg Internment Camp in 1915. The principal medical officer, Dr. Ashenbach, immediately fled. Major Priestly, R.A.M.C., at once took charge although the conditions were simply beyond expression, and he was instrumental in saving many lives. We are very glad to be told by the *Hospital*, of London, that Major Priestly has been awarded the gold medal of the West London Medico-Chirurgical Association for his signal attention to duty at that time.

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*Recent Graduates.*—The following candidates passed the final examinations at McGill, thus qualifying for the degree of M.D.: Alex. M. Bell, Max M. Bloomberg, H. E. Britton, B. A. Brown, N. S. Burrows, E. M. Busby, J. R. Calder, E. B. Carter, L. E. Chantal, G. A. Cheeseman, W. J. Cochrane, C. G. Clements, J. R. Dean, C. L. Derick, W. R. Dowd, C. W. Duck, L. C. Dursthoff, E. H. W. Elkington, J P. Fawcett, M. Francis, L. Goldfield, A. H. Greenwood, F. O. Greenwood, M. C. Hamilton, L. G. Hillier, W. M. Hustler, G. C. Kenning, R. A. MacArthur, R. H. MacLauchlan, T. D. McGregor, G. J. McMurtry, W. Morrish, A. R. Newsam, S. H. O'Brien, P. H. Patterson, H. H. Pitts, F. T. Reid, H. J. Robillard, H. E. Skeete, R. R. Struthers, R. B. Taylor, C. E. M. Tuohey, W. H. Turney.

A new hospital is being built at Kananaskis, near Banff, Alta. The estimated cost is $400,000, of which the Dominion Government and the Province of Alberta will each pay one half. It will accommodate 300 patients, and when no longer required for military purposes, will become the property of the province for civilian patients.

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After very arduous work for nearly three years, Capt. E. Ryan was compelled, on account of illness, to take a temporary rest in March. He spent one year overseas at the Ontario Hospital at Orpington, where he had charge of a section with 110 beds, occupied chiefly by soldiers suffering from shell shock and other nervous affections. He also visited a number of Imperial hospitals to visit and report on the condition of the Canadians being treated. He was chief officer in the construction and equipment of many military hospitals. Among these were the North Toronto Orthopædic Hospital, the Newmarket Military Hospital and the New Hospital at Guelph.

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**Simple Honesty**

Recently a non-commissioned officer of a popular contingent at Camp Mills was mistaken by a new recruit on sentry duty, who saluted him. The non-commissioned officer, ignorant that his colonel was nearby, returned the salute. Next morning he was ordered to report to the colonel, where he was asked why he returned the salute when he, the "non-com," knew he was not entitled to it.

"Sir," he answered, "I always return everything I am not entitled to."

The colonel dismissed him.—*Ex.*

# Personals

Dr. F. E. Birdsall (Lt.-Col.) took over the command of the District Depot, Kingston, April 16th.

Dr. R. J. Manion, M.P., Fort William, went from Ottawa to Cornwall, April 14th, to attend the funeral of the late John McMartin, M.P., representing the Dominion Government.

Dr. R. J. P. McCullough announces that he has opened an office at 102 College Street, Toronto, and that his practice will be limited to diseases of the eye, ear, nose and throat.

Lt.-Col. K. D. Panton, of Vancouver, B.C., went to France with one of the earliest contingents. After serving for some time in Flanders, France and Greece, he was sent to England, and placed in charge of the Canadian Hospital at Eastbourne.

Dr. Alex. McKenzie, of Toronto, returned to Canada after prolonged service at the front, in March. The first week in April he was ordered to Halifax to take charge of military medical matters in that region.

Dr. B. M. Luton (Maj.) of St. Thomas, a winner of the military cross, who has been over two years in the military service in France, returned from overseas in March, and has been appointed O.C. of the new Military Hospital at Fredericton, N.B.

Dr. Wm. C. White (Tor. '99), C.A.M.C., who practised for some time in Pittsburg, and went overseas early in the war, has been made chief of the Bureau of Tuberculosis of the American Red Cross in France.

Dr. R. J. MacMillan and Dr. A. D. Moorhead, of Toronto, who went overseas as surgeons last November, are both well and busily engaged in a military hospital in Havre, France, when last heard from.

Lieutenant Stanley Reaume, son of the Honorable Dr. J. O. Reaume, now Registrar for Essex County, was wounded in France, April 9th. Young Reaume was well known in connection with sports in Toronto, especially as a Rugby player with the University of Toronto, and the Argonauts.

Dr. Wm. Gunn, of Clinton, after active service overseas for two years, has returned and resumed practice.

Maj. Bruce Robertson, C.A.M.C., who was for some time attached to No. 2 Canadian Casualty Station, has returned to Toronto.

The late Jas. L. Carter, Sarnia, Ontario, bequeathed $30,000 to the Hospital for Sick Children, Toronto.

Dr. M. M. Seymour, Commissioner of Public Health, Sask., opened a new hospital at Eston, Sask., January 13th.

Capt. J. D. Shields, C.A.M.C., has returned from active service overseas, and has been made a member of the Pension Board at Ottawa.

# Obituary

## T. V. HUTCHINSON, M.D.

We have to announce with deep regret the death of Dr. T. V. Hutchinson, which occurred in Toronto, March 19th. He was for nearly forty years M.O.H. of London, Ontario. After resigning from that position, he moved to Toronto.

## LIEUTENANT-COLONEL HARRY BLAYLOCK

Lt.-Col. Harry Blaylock, formerly of Guelph, and then for some years a resident of Calgary, has been appointed Overseas Red Cross Commissioner in place of Col. Hodgetts, C.M.G., resigned. Col. Blaylock was living in London, Eng., when the war broke out and soon volunteered to work for the Red Cross. For more than three years he has done admirable work for the C.A.M.C. Hospitals in France.

## LIEUTENANT-COLONEL JOHN McCRAE

It has been said that John McCrae was the most talented man in the medical profession in Canada, and that is probably true. By that we mean that over and above his undoubted ability in general medicine he possessed talents of varied order, which he at least did not wrap in a napkin and hide. His reputation as a poet is already established on both sides of the Atlantic. His knowledge of general subjects such as history and biography, military work and general literature, both French and English, was unusually extensive.—*C. M. A. J.*

# Book Reviews

A *Manual of Clinical Diagnosis.* By means of Laboratory Methods for students, hospitals, physicians and practitioners. By Charles E. Simon, B.A., M.D., Professor of Clinical Pathology and Physiological Chemistry in the University of Maryland, Medical School and College of Physicians and Surgeons, Baltimore, Md. Ninth Edition, enlarged and thoroughly revised. Illustrated with 207 engravings and 28 plates. Lea & Febiger, Philadelphia and New York, 1918.

To have reached the ninth edition is a sufficient warrant to prove that a book was needed, and that it supplied the want. Professor Simon has thoroughly revised this edition, and added many of the newer tests, particularly useful in blood and serum work. Always noted for its clearness, this new volume has improved even on the others, and is a model text-book to put into a student's hands, or to place on the shelf of a practitioner who must keep up to date.

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A *Text-book of the Practice of Medicine.* By James M. Anders, M.D., Ph.D., LL.D., Professor of Medicine and Clinical Medicine, Medico-Chirurgical College Graduate School, University of Pennsylvania. Thirteenth edition, thoroughly revised, with the assistance of John H. Musser, Jr., M.D., Associate in Medicine, University of Pennsylvania. Octavo of 1,259 pages, fully illustrated. Philadelphia and London: W. B. Saunders Company, 1917. Cloth, $6.00 net; half morocco, $7.50 net. W. B. Saunders Company, Philadelphia, London. Canadian Agents: The J. F. Hartz Co., Ltd., Toronto.

Thirteen editions of this standard text-book in twenty years says more for its merits than any long review. Many of the articles have been rewritten to comply with recent advances, and much new matter has been added, because of progress in the science, particularly along the line of specific therapy, and some diseases in which the causative organism has been recently demonstrated, such as rat-bite fever and typhus. The book abounds with illustrations and tables, so that it is better fitted than ever to find a place on the doctor's shelves.

*The Spleen and Anæmia.* Experimental and Clinical Studies. By Richard Mills Pearce, M.D., Sc.D., Professor of Research Medicine, with assistance of Edward Bell Krumbhaar, M.D., Ph.D., Assistant Professor of Research Medicine, and Charles Harrison Frazier, M.D., Sc.D., Professor of Clinical Surgery, University of Pennsylvania. 16 illustrations, color and black and white. J. B. Lippincott Company, 201 Unity Building, Montreal.

Nothing which has been done in America can surpass the work of these three research workers for clear, concise and accurate investigation. This volume forms at once a complete epitome of what has gone before, with an account of the painstaking labors in the University of Pennsylvania, so that we have an interesting monograph of the whole subject. The illustrations and press work are above reproach, and the book is a credit to both publisher and authors.

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*Essentials of Prescription Writing.* By Cary Eggleston, M.D., Instructor in Pharmacology, Cornell University Medical College, New York City. Second edition. W. B. Saunders Company, Philadelphia and London. 1917.

The object of this little pocket volume of 125 pages is to provide the student of medicine with a succinct, yet sufficient, treatment of the subject of prescription writing. This new edition has been carefully revised and enlarged, and brought into line with the needs of the student.

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*Progressive Medicine.* A quarterly digest of advances, discoveries and improvements in the medical and surgical sciences. Edited by Hobart Amory Hare, M.D., Professor of Therapeutics, Materia Medica and Diagnosis, in the Jefferson Medical College, Philadelphia; assisted by Leighton F. Appleman, Instructor in Therapeutics, Jefferson Medical College. Volume I. March, 1918. Lea & Febiger, Philadelphia and New York.

This volume contains surgery of the head, neck, breast and thorax; infectious diseases; diseases of children, and rhinology, laryngology and otology. In spite of the war, with consequent dearth of original articles, "Progressive Medicine" continues

to lead in the field of epitomes which it so ably represents. The conditions which are taken up in this volume are ably dealt with by capable men, and the results of the year's work are summarized in a most readable manner.

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*International Clinics.* A quarterly of illustrated clinical lectures and especially prepared original articles, by leading members of the medical profession throughout the world. Edited by H. R. M. Landis, M.D., Philadelphia. Volume I, twenty-eight series; 1918. Philadelphia and London: J. B. Lippincott Company.

These are real clinics, prepared by live, enthusiastic practitioners for post-graduate students, who can have them at home instead of at a large hospital. Then there are interesting articles on various topics, and the volume concludes with a summary of the progress of medical science for the past year. Altogether this is one of the most useful books which could come to a man in general practice.

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### A Safe Answer

"Henry," said his wife, sharply, "whom do you regard as the greatest general in history?"

"Joan of Arc, my dear," answered Mr. Meekton, promptly, desiring peace.—Boston *Transcript.*

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### A Small Contract

"What are you drawing, Johnny?"

"This is a picture of God."

"But you can't do that, child; nobody knows what God looks like."

"They will when I get done."

# Selections

## Acute Lobar Pneumonia

In the *Boston Medical and Surgical Journal*, Shattuck and Lawrence, after an exhaustive analysis of many cases, reach these conclusions:

1. In the four thousand odd cases of lobar pneumonia, treated at the Massachusetts General Hospital, from 1822 to 1917 (inclusive), the mortality has gradually increased 10 per cent. in the first decade to 28 per cent. at the present time.

2. Since 1881 there has been no significant change in the death-rate.

3. The number of cases classed as delicate or intemperate has been decreasing during the same period.

4. The apparent increase in complicated cases is probably due to increased accuracy of diagnosis and recording.

5. The relative number of foreign-born patients is increasing, the mortality among them diminishing.

6. The death-rate among the American-born has increased slightly, as has the mortality among men as compared to women. This may be due to a corresponding increase in vascular diseases during the period studied.

7. The mortality rate for pneumonia in the entire series has shown no permanent important change.

8. Treatment has done nothing toward diminishing the mortality from pneumonia in the past ninety-five years. Bleeding, purging, fresh air—the result has been the same. Of particular interest is the evidence offered by the writers' figures upon the effect of alcohol. Its habitual use, during health, in more than moderate amounts, is shown to diminish the patient's chances of recovery. But the mortality rate among those patients who were given large amounts of alcohol during their illness is no higher than among those given no alcohol and large amounts of fresh air. The writers' figures do not indicate that alcohol is harmful to those sick with pneumonia. They suggest that the effect of the drug varies with the conditions under which it is given, and that it is not poisonous to those who have high temperatures and are taking insufficient nourishment.

9. No change is to be expected in the results of treatment until a specific is discovered which will neutralize the toxins of the pneumococcus.

10. The results from the serum now in use are encouraging, but limited, and until its use becomes accepted, the treatment of pneumonia must be that best suited to the individual. No routine treatment has been justified by its results.—*The Therapeutic Gazette.*

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### The Diagnosis of Duct Cancer of the Breast

J. Laurence (*Journ. des Praticiens*).—The frequency with which cases of cancer of the breast are found to be inoperable, or only operable with a greatly diminished chance of success when they are first seen by the surgeon, has often been remarked. In the majority of such cases the responsibility rests with the patient, either through ignorance or concealment of her condition. There is, however, a variety of cancer of the breast which, from its liability to be overlooked or wrongly diagnosed, is apt to leave the medical attendant under the reproach of having misled his patient as to the gravity of her condition until the disease has attained a stage too advanced for operation. This is the intracanalicular papillary epithelioma of the breast, developed in the cylindrical epithelium of the excretory ducts rather than in the secreting acini of the mammary gland. The first symptom to attract the attention of the patient is a discharge from the nipple, which is often serous, sometimes reddish, most frequently strongly blood-stained, and occasionally apparently composed of pure blood. Examination of the breast at this stage may reveal nothing abnormal, as no tumor may be felt. In fact, the discharge from the nipple may precede the appearance of a tumor by months, and, in some cases, even by years. The discharge may even be intermittent, and in some cases has been observed only during menstruation. When a tumor develops it is rarely visible on inspection, but requires for its recognition minute and careful palpation. It may occupy any part of the breast, but its most frequent site is in the vicinity of the nipple. It is usually small, ranging from the size of a pea to that of a walnut. It is well defined, independent of the skin and mobile in the breast itself. Its consistence is firm and elastic, and it is usually painless on pressure. The tumor is of slow growth, and may remain apparently stationary for years. The general health is unaffected and the lymphatic in-

fection does not occur during this stage. When the walls of the galactiferous ducts become softened and destroyed, this long benign period comes to an end, and is succeeded by a stage of rapid malignancy. The papillary epithelioma then loses its peculiar structural character and the disease assumes the appearance and course of a rapidly growing carcinoma.

The temptation to make light of a slight discharge from the nipple without definite tumor and unaccompanied by general symptoms, is easy to understand. A means of investigation which should never be omitted is the microscopical examination of the discharge, which may contain cells undergoing characteristic malignant changes. Even should this examination prove negative, a serous or blood-stained discharge from the nipple of a woman past middle life should be regarded with suspicion and the examination repeated at short intervals, with minute and careful palpation of the breast. If a tumor is found, no matter how small, recourse should be had to a biopsy, should the diagnosis remain doubtful. Especially should one refrain from the application of pastes, iodine, or radiography for long periods. In all cases of cancer, especially in cancer of the breast, the only effectual treatment at present known is early and free removal of the disease. Any treatment which permits the affection to develop while giving the patient a false sense of security, cannot be too strongly condemned.—*The Medical Record.*

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### Earache and its Management

Rufus B. Scarlett (*N.Y. Med. Jour.*) draws attention to the significance of earache, with its complications, and states that its seriousness is often not recognized. The character and location of the pain may be confusing in at least three conditions. (1) In furunculosis, it may be distinguished by the patient as anterior to the middle ear and as becoming more intense as the lobe of the ear is disturbed. (2) The distress in middle ear infection is usually centred in the ear, and not necessarily affected by motion of the lobe. (3) When the Eustachian tube is involved in an inflammatory process pain and tenderness usually extend down the neck along the course of the tube. Scarlett states that every physician should be able to detect the existence of any pathological condition of the drum or its neighboring structures and points out that sagging of the wall of the external canal is suggestive of involvement of the mastoid cells.

For the relief of pain a saline cathartic should be given and dry heat applied; moist applications favor venous engorgement, soften the tissues, and hasten local necrosis. Rest in bed is essential. Attention to the nasopharynx and depletion of the tissues surrounding the orifice of the Eustachian tube is important in order to encourage drainage from the middle ear. The dropping of oily solutions into the external auditory canal is unwise. Should relief not be obtained within twelve hours an incision should be made in the tympanic membrane, especially if the presence of fluid in the middle ear is detected. In the majority of cases this can be done under local anæsthesia, and to produce this various preparations have been suggested; the author has found a combination of the crystals of cocaine, carbolic acid, and menthol most satisfactory. Local applications of cocaine, eucaine, or alypin to an intact tympanic membrane produce little effect, as the external surface of the drum is covered by a dermal layer. Such solutions are effective if injected beneath the skin at or near the point of incision, but the injection is almost as painful as the incision would be without anæsthesia. A preparation consisting of cocaine crystals, aniline oil, and absolute alcohol, and extensively advocated a few years ago, has been found to produce toxic symptoms. Should general anæsthesia be deemed advisable, chloroform, ethyl chloride, or somnoform may be used; nitrous oxide is more troublesome. A free incision should be made by a *sharp-pointed* miniature bistoury at the point of greatest bulging. Care must be taken to avoid injury to the incus and stapes, and the point of the bistoury must not penetrate too deeply. After the incision has been made the canal should be mopped dry and a small wick of gauze loosely inserted to encourage drainage. The canal must subsequently be frequently cleansed with cotton, and as much moisture as possible eliminated. Should the discharge become copious a mild antiseptic is of value. Care of the nose and throat is essential, and as certain relaxation of the drum membrane and intratympanic ligaments follows inflammation, precautions must be taken to guard against complications. The middle ear should be carefully inflated, at first daily, until all traces of congestion have disappeared, hearing has been restored, and the tympanic membrane retains its normal position.—*Medical Record.*

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P.—4

# Miscellaneous

### Gonorrhœa in Women

The application of an aqueous solution of iodine in connection with the administration of sanmetto is recommended in the treatment of gonorrhœa in women, on account of its ability to penetrate the subepithelial structures and deeper glands. It is also a stimulant, a counter-irritant, and an alterative. The aqueous solution (Liquor iodi compositus) is used because of the pain caused by alcoholic tincture. The gonococci disappear early from the secretions, intrapelvic extension is far less frequent, and there is little pain. The entire course of treatment is comparatively short and causes but little trouble to either patient or physician. In acute and sub-acute cases, where vaginitis or vulvitis is present, the patient should be directed to use one teaspoonful of the solution to two quarts of warm water as a douche twice daily. In the chronic and mildly inflammatory cases, the strength should be gradually raised from one to two teaspoonfuls, or until the patient begins to experience a burning or smarting sensation, indicating the limit of increase, the sanmetto to be administered in teaspoonful doses four times daily throughout the treatment.

### The Management of Abnormal Blood Pressure

In the discussion of high blood pressure and its significance, it is sometimes forgotten that hypertension is an effort to establish circulatory compensation, and therefore is in itself physiological. According to Thomas E. Satterthwaite, in an article published in *International Clinics,* Vol. III, series 27, this point should be always remembered in the management of hypertension. The diet should be regulated so as to limit the amount of protein, and in general to prevent the formation of acids in the system resulting from the development of putrefactive processes. Bulgarian sour milk or ordinary buttermilk is sometimes useful in combating intestinal toxæmia, and it is best combined with vitchy in the proportion of from one-eighth to one-half. Fresh vegetables and milk should be taken freely. No pastry, coffee, tea, alcohol, or tobacco should be permitted, or very sparingly taken. The Karell treatment of a glass of

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milk at 8, 10, 4, and 8 for two consecutive days may be helpful in acute cases, the patient resting in bed. Rest is also important, but properly controlled exercise, active or passive, according to the severity of the symptoms, may be of service. No excitement of any kind should be permitted. Constipation should be avoided and care should also be taken to see that there is no excessive functioning of the adrenals and the other ductless glands, the secretions of which, if in excess, produce hypertension.

Satterthwaite is greatly in favor of the use of the high frequency current, given two or three times a week in seances of eight to ten minutes. As for drugs, iodine should be administered in moderate doses, and iron if a tonic is required. Nitroglycerine, alone or with other drugs, may be given in sufficient doses to reduce the pressure, if that is desirable, but it should not be administered in doses sufficient to produce a prolonged headache. On the other hand, the use of digitalis need not be feared in cases of high blood pressure. According to Burnet, writing in the *Medical Press* of August 21, 1912, the tincture of digitalis does not raise the pressure—a fact, if it be a fact, which is not generally known. The use of chloral hydrate is not recommended, but sometimes the bromides give satisfactory results. Satterthwaite uses aconite in one-minim doses more than any other drug.

Of course, in the treatment of hypotension, rest, mental and physical, is very important, and digitalis, strychnine, and preparations of iron or manganese are helpful. If the hypotension is due to adrenal insufficiency, Satterthwaite has found two-grain doses of the dried gland three times a day useful, or 1½ grains of the dried adrenal with 1/10 grain pituitary gland about three times a day. Such patients should have plenty of outdoor air and mild passive exercises and massage.

It should be borne in mind that in all cases of abnormal blood-pressure hypertension has, on the whole, a far more unfavorable prognosis than hypotension, which, except after loss of blood in shock, in acute cardiac dilatation in the course of infective diseases, is not a cause of immediate alarm. For the most part, hypotension indicates mathematically the degree of exhaustion in wasting diseases, such as tuberculosis. On the other hand, hypertension is usually associated with arteriosclerosis, when the degree of it measures approximately the danger from nephritis or cerebral hæmorrhage.—*Medical Record.*

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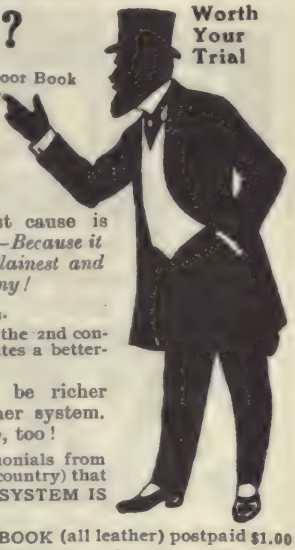

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### Permits for Visits to Foreign Health Resorts

All cross-Channel traffic has for some time been reduced to the lowest limits consistent with the national interests, and permits are now limited to those cases in which the absolute necessity of the journey can be established. Any application for a permit on the ground of ill-health must be supported by a doctor's certificate stating that the journey is an absolute necessity, and specifying the place of resort and the length of stay proposed. The medical man must also certify that there is no health resort in Great Britain which would meet the case. When the patient requires a companion, the medical man must include in his certificate the statement that a companion is essential, and the name of the companion. The regulations practically apply solely to persons who consider that it would be to the advantage of their health to visit some place on the continent, most usually the Riviera. The utmost discrimination should be exercised by medical men in giving the certificates, when the total number which need be given will be small, as many conditions of health or constitution can find suitable environment in a health resort in Great Britain. There is no doubt, however, that where an altitude above 4,000 feet or low absolute humidity is desirable for a patient, such conditions can only be obtained on the continent. The regulations do not apply to persons seeking permission to visit a wounded relative. —*The Lancet.*

### War Savings

After the war is over international relations, as well as the political organization and the economic policy of the world, will be different from what they were previously. The old principle of *laissez faire, laissez aller* is being rapidly swept away by war efficiency, and it can never be resuscitated to the extent to which it prevailed before the present cataclysm. Under the system of *laissez faire* we admittedly tolerated a great deal of waste. We have built up an easy-going philosophy of spending and we indulged in a wastefulness equalled, perhaps, by no other nation. The grim realities of the present, in the face of the stupendous undertaking which we must carry to a successful finish, call for a revision of our theories of easy spending as fundamental for general prosperity. Economists have repeatedly pointed out that extravagant consumption prevented the concentration of labor and capital in basic industries. Now

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is the time for heeding their advice. We should put all our capital and energies into the industries which will make for the greatest effectiveness of this nation in the present struggle. All the non-essential things should be eliminated and a campaign of intensive saving encouraged. It is not only the advantage which accrues to the individual from practising thrift that is important. It is the increase in the productiveness of the essential industries which will ensue if the demand for the customary comforts shall have been materially decreased. In spite of our living in one of the largest communities of the world, we are governed in our expenditures by the standards prevailing in the immediate group of our friends and associates. We must conform to the requirements of the group with which we associate if we do not wish to be *déclassés*. The National War Saving Committee has very wisely recognized this sociological fact and is endeavoring to use the group as a means of enforcing war saving. It is accordingly calling upon the associations of all kinds to organize thrift circles. The movement has been started recently and promises to bear excellent results. Physicians can help in this splendid work by stimulating such collective saving facilities in their professional connections and through such organizations as the hospitals and dispensaries.—*Medical Record.*

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**Prophylaxis in Venereal Diseases**

Under this heading the *Lancet*, in a leading article, calls attention to a recent discussion of the Congress of Venereal Diseases of the question of artificial prophylaxis, and quotes the resolution to be submitted to this body, which runs as follows:

"In view of the public attention now directed to the whole subject of prophylaxis, the Executive Committee, after careful consideration, is not prepared to depart from its original position, in which, in accordance with the spirit of the Royal Commission's report, it refrained from recommending the adoption of prophylaxis—*i.e.*, the provision of outfits to men before sexual indulgence. The committee strongly urges the importance of the making of arrangements for the early treatment of venereal diseases even before the onset of symptoms."

The *Lancet* believes that the preventive in venereal diseases among the troops should start earlier than it does now. The Canadian, Australian, and especially the New Zealand troops

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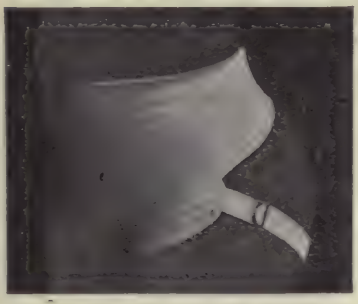

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have suffered greatly from venereal disease, and, with regard to the last, the *Lancet* has been supplied with figures which almost justify the phrase employed in the communication to the effect that "London is the plague spot of the world." There can be no doubt that the feeling among numerous officers of the colonial troops is that the facilitation of artificial prophylaxis is necessary for the safety of their men, while many are convinced that the control of loose women would greatly increase the fighting strength, and would annul the risk that the soldiers may carry back to their homes hereditary disease as well as the glory of having fought for their country.

To these feelings every consideration is due; and, if the views expressed can be supported statistically, the country at large will hold that the National Council for Combating Venereal Diseases have a responsibility put upon them by the war that was not upon them when they were created to carry out the valuable conclusions of the Royal Commission.

We are in the face of military facts: all men are wanted, and venereal disease prevents a certain proportion of them from responding to the call. Measures might quite sensibly be taken now which would have no justification in normal times; nor would a change of attitude at such a juncture mean a permanent return to discredited social tactics. We are at this moment reconciled, with a unanimity that would have been quite inconceivable three years ago, to the distribution of bombs by aeroplanes upon German cities. Does anybody believe that the spirit thus indicated is likely to remain a permanent national spirit of the country? In the same way, we do not for a moment suppose that, if it should be found wise to-day to control the action of certain women in certain military areas, or to recognize the existence of illicit coitus by instituting a system of supply to sailors and soldiers of prophylactic apparatus, we should be committed in the future to the lower state of public morals indicated by such methods. These are some of the more important points which the National Council for combating Venereal Diseases will have before them at their meeting, and they will be debated frankly and no restraint will be put upon the expression of opinion by the allegation that to depart from a line of conduct hitherto followed is either to do ill with the illogical hope that good may come, or to display a cowardly inconsistency. It requires knowledge to decide what an ill deed really is, and it requires courage to deal with facts which contravene an accepted course of procedure.—*The Therapeutic Gazette.*

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The Typical Chlorotic Picture is one that is quite familiar to every practitioner of experience—the peculiar pallor of the skin, the livid lips, the colorless conjunctivæ, and the characteristic expression of anxiety. Add to this the hæmic murmur or the venous hum, with the low percentage of hæmoglobin, as shown by the hæmotologic test, and the diagnosis is not difficult. A rapidly acting blood builder is the " sine qua non " in such cases, and should be promptly ordered. It is important, however, that the hæmatinic prescribed should be free from irritant action upon the digestive mucosa, while, at the same time, quickly absorbable and assimilable. Pepto-Mangan (Gude) fully meets these requirements, and if given steadily and persistently will undoubtedly promptly revitalize the dehæmoglobinized blood and thus restore vital resistance, color, strength and appetite. Fresh air, good food and general hygienic treatment is, of course, also indicated.

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### Exploratory Laparotomy

Parkes (*Surg. Gyn. and Obs.*) considers exploratory laparotomy has a more limited place than usually accorded it, and should only be undertaken when all other diagnostic aids have failed. In acute conditions it should be preceded more often by careful treatment. It should not be undertaken unless the operator has the qualifications to successfully deal with the possible discovered conditions and has a sense of the value of tissues and organs. Careful planning of an operation is advisable beforehand, but should not be held to inflexibly. Operation following a hasty diagnosis by the surgeon himself is deplorable, but on the diagnosis only of someone else is incredible, but it is often practised. Reform is needed, and it must come by spontaneous realization of the harm done by unintelligent and dishonest practice.—*Medical Press.*

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### A New Diagnostic Sign in Gastric Ulcer

F. Grande Rossi describes a new sign which he claims to have discovered in the diagnosis of gastric ulcer and which consists in painful reaction to pressure made at a point four centimeters to the left of the navel and in the bisecting line of the second quadrant. To obtain it, pressure should be made with

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one or two fingers backwards and inwards towards the spinal column, the patient being lying down and with the abdominal walls relaxed. Grande Rossi says that the sign is very constantly present in all cases and he has obtained it in over 400 cases. The intensity of the pain decreases as the patient becomes better and returns with the relapses. The sign is present even in some cases in which other classical symptoms may be absent, and he has proved it to be true in all cases by the use of other methods, as Einhorn's thread examination of the gastric juice, and of the fæces, hæmorrhages, X-ray examination, etc.—*Medical Record.*

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### Vanadium as a Tonic

In a recent issue of *Paris Médical,* reference is made by le Tanneur to the value of vanadium peroxide as a tonic in the case of soldiers convalescent from wounds or worn out by active service. The salt is obtained from vanadium iron ore, which occurs in South America, and is rich in oxygen. It acts specially on the liver, being a mild cholagogue, and increases the number of red blood corpuscles. As it is practically non-toxic, it may be given in infantile diarrhœa. With adults it acts as a true tonic, being tolerated by the most delicate stomachs. It is also useful in dyspepsia and enterocolitis.—*The Prescriber.*

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### The Dangers of Intravenous Injections of Strophanthine.

H. Curschmann states that the practice of giving intravenous injections of 0.7 to 1 mgm. of strophanthine is not without danger, is shown by the two following cases. A patient suffering from a moderate degree of cardiac and renal insufficiency was given an intravenous injection of only 0.3 mgm. of strophanthine. Severe collapse, with signs of heart failure, ensued. Another patient, who had previously been given 3 small injections, died an hour after an injection of 0.8 mgm., with signs of heart failure. The writer urges the adoption of smaller doses, and suggests 0.5 mgm. as the maximum dose. Smaller doses than this should be given at first in cases of serious cardiac insufficiency.—*The Medical Record.*

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### Starch Iodide for Infected Wounds

A. Lumière (*Presse Médicale*) finds that the application of starch iodide to wounds, especially to those of the soft parts, causes very rapid sterilization of the wound. In deep wounds successful results were secured by irrigations of starch iodide after the method of Carrel. The solution employed consisted of soluble starch, 25 gm.; boiling water, 1000 gm.; iodine iodide solution (1 : 1000), 50 c.c. This fluid seems to possess antiseptic power of the same order as Dakin's solution, and is not irritating to the skin.—*The Prescriber.*

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### The Gem Ear Phone

A great deal of thought, a vast amount of energy and a good-sized fortune have been expended in an effort to solve the perplexing problem of making the deaf hear, and ear trumpets, horns, ear-drums and various devices of one kind and another have been invented, patented and placed upon the market. All have fallen far below their maker's expectations and have failed to give genuine satisfaction. Not until an electrical hearing device, based on the true scientific principles of the telephone, was invented, has any real progress been made in solving this problem.

Amongst the newest inventions in hearing devices, based on the microphonic sound-reproducing principle, is the so-called Little Gem Ear Phone. Although small in size, it is very sensitive, and was awarded the gold medal at the Panama-Pacific Exposition. In cases where medical treatment does not respond satisfactorily, it would be well for doctors to consider this instrument. It assists the hearing and at the same time, owing to its electric vibrations, brings the circulation of the congested parts to almost its normal condition. The instrument consists of a sound transmitter, with regulating device on the back, receiver and a battery. The three parts are electrically connected; the sound waves striking the transmitter are conducted in a magnified state to the receiver.

The Gem Ear Phone Co. of Canada have an office in Toronto, situated in the Royal Bank Building, where demonstrations are given freely to everyone desiring to test the instrument. A demonstrator will call by appointment.

# The Canadian Practitioner and Review

Vol. XLIII. TORONTO, JUNE, 1918 No. 6


## Article

### THE TREATMENT OF SYPHILIS*


By Major H. C. Donald, R.A.M.C.


Although treatment by "606" and Hg has been in use for eight years, it is only since the war it has been carried out on such a gigantic scale, and involving so many practitioners. I think "606" has well justified its short existence in the treatment and, I hope, cure, of syphilis.

In the Army, Harrison has shown that before the use of "606," when long courses of Hg were the recognized treatment, 83 per cent. of soldiers suffering from syphilis treated with Hg alone required re-admission to hospital at least once during the first year for relapse, while since the introduction of "606," combined with Hg, less than 1.3 per cent. of soldiers have required re-admission. This latter percentage is taken from records of over 10,000 cases treated. During the days of Hg, the patient was detained in hospital for an average of 66 days; now, with a full course of "606" and Hg, 49 days, which is a considerable saving of wastage of man-power to the army.

I might mention the different preparations I have seen used in the army since the outbreak of war—mainly, "606," Kharsavan, Arsenobenzol, Galyl, Luargol, and Intramine.

The first three are most commonly in use, and have all proved equally successful in results; they have much the same effect, same dosage, and might be classified as one.

*Galyl* has been used on occasions, but has not proved so efficacious or destructive to the spirochæta. It has the advan-

*Paper read before the Royal Academy of Medicine, March 22nd, 1918.

tage that it is easily mixed, and is given intravenously with a Record syringe. It is less toxic, but becomes oxidized quickly, so must be used at once. It is also claimed that it is not toxic, but cases of reaction with convulsions, albuminuria, and dermatitis have been recorded. It has further been used intramuscularly, but did not kill the spirochæta.

*Luargol.*—Introduced comparatively recently, has silver and antimony in combination. I have seen a number of cases treated with this preparation, and with apparently good results, but cannot speak as to the lasting effect it has had in these cases. It has the advantage of Galyl that it is easily mixed, but has the disadvantage that it frequently causes thrombosis of veins. It is claimed that it is useful in advanced or late cases of syphilis and syphilis of the nervous system.

*Intramine.*—Introduced by McDonagh, I have seen it used in eleven cases of syphilis, primary and late, but cannot say that I saw any marked improvement in the lesions ten to fourteen days after the treatment, nor had the drug an immediate effect on the spirochæta. I believe that now McDonagh is combining four doses of "606" with intramine in his course. It is claimed that intramine has good effects in the treatment of arsenical dermatitis. I have seen it used in one severe case, but cannot say that it had any striking effect on this distressing complication or shortened the course of the disease.

Of Ferrivine, also introduced by McDonagh, I have no experience, but believe it gives rise to alarming symptoms of dyspnœa and shock immediately following its administration. I don't think it has been extensively used, at least as far as I know, not being used at the present time.

Regarding the method of administration. At the beginning of the war the intravenous method allowing the solution to flow into the veins by gravitation, was mostly in use, and less so by injection into the veins. With "Neo" or "Nova" preparations the method gives excellent results, has no untoward reaction as a rule, and causes little or no inconvenience to the patient, who has the usual careful supervision for 24 hours after the injection.

Within the last year or eighteen months, a tendency has been to return to the intramuscular or deep subcutaneous injection of the preparation, and I personally believe it will some day be the most successful and simple method of administration of "606," and well suited to dispensary practice. It will do away with the elaborate and exacting mixing and neutral-

izing of the drug, which is only safe in the hands of an expert. It does not give rise to the same risk of reaction, and altogether, I think it is safer.

The slow and gradual absorption and excretion by the intramuscular deep subcutaneous method is a strong argument in its favor, and bacteriologists have most favorably commented on its destructive effect on the spirochæta and the lasting effect on the Wassermann result.

Perhaps on account of slow absorption and slow excretion, the drug remaining in the system for an indefinite period, we might be able to reduce or stop the combination of Hg, which, I believe, tends to render "606" more toxic, and has a more or less destructive action on the liver, and, further, frequently gives rise to stomatitis.

The objection to this method of administration is the amount of local pain and discomfort it sometimes causes. To overcome this local pain and discomfort, anæsthetics have been suggested—such as mixing "606" with stovaine or giving a hypodermic injection of morphia later.

My experience is that these do not help much, and simply mixing the dose in ten or twelve minims of distilled water, diffusing the solution as well as possible while injecting, and massaging the buttock well afterwards, seem to serve the purpose quite well.

I have no doubt in time the drug will be adapted so that it will be given painlessly by this method. Another objection is that abscess formation or necrosis at the seat of injection sometimes occur. The method, I believe, will appeal to local authorities when they take up fully the treatment of syphilis, when bed accommodation will be a consideration, and when cases treated intravenously require to be under observation for perhaps 24 hours after the first two or three injections.

Cases of syphilis preparatory to the commencement of treatment by "606" should be carefully examined, attention being specially directed to general health, condition of teeth and gums, presence of albumin, and the weight should be recorded; also, if he has had any previous tendency to dermatitis of any kind, or severe malaria or jaundice, and the doses regulated accordingly.

Regarding the questions put forward by Dr. Kirkpatrick, I consider the course at present in use in the army, and suggested by Lieut.-Colonel Harrison, Rochester Row, London, the best. "606" or any of its equivalents is used as follows:

Seven weekly doses of "606" intravenously, commencing with 0.3 gramme for the first three doses, followed by three doses of 0.4 gramme, and finishing up with one dose of 0.5, a total dosage of 2.6 grammes being given. If administered intramuscularly, two .45 gramme doses, followed by five .6 grammes, a total of 3.9 grammes being given. With each dose a weekly dose of 1 grain of Hg is given intramuscularly in the form of mercurial-cream. If at the end of the course the patient's blood gives a negative Wassermann, he is left alone, and directed to have a blood test at the end of two, four, six, and twelve months. This was an important result of treatment by newer drugs owing to the absence of any lowering of vitality. Soldiers were quite fit to return to duty at once without any convalescence; in fact, were usually much improved in general health. If, however, the blood is positive or doubtful, he is put on a course of iodid of potassium for fourteen days, and at the end of that time receives a further two weekly doses of .3 and .4 grammes of "606" and 1 gr. Hg. Tertiary cases receive the same course, which is repeated after intervals, during which KI and Hg is administered. Each case must be treated on its merits, and one is guided by the repeated Wassermann results. In spite of many such courses there are a number of late cases of syphilis which will never give a negative Wassermann. Regarding the question of cure, all active signs having disappeared, and repeated Wassermann examinations proving negative at intervals of every three months during the first year and six during the second, the examination before the late tests being preceded by the administration of a provocative dose of "606," and, in addition, the cerebro-spinal fluid proving negative, I think one could reasonably give the patient a clean bill of health.

It is necessary to determine the Wassermann reaction of the cerebro-spinal fluid before pronouncing a patient as cured. Statistics show that 100 per cent. of cases treated with "606" show a negative Wassermann after two and four months, while Gennerich found, of 162 cases of primary and secondary cases treated for less than six months by "606" and Hg and observed for two years, 151 remained negative to Wassermann examination of blood and cerebro-spinal fluid.

I have not seen many cases of syphilitic diseases of the nervous system in the army during the war, at least advanced conditions; but of those I have seen what has struck me has been the striking improvement of the symptoms under "606" and Hg treatment. I might just mention one case that I have

under treatment at the Military Hospital, Portobello, at present. A discharged soldier, aged 49 years, but looking much older, with marked signs of tabes, practically crawling, with loss of control of bladder and rectum, presented himself for treatment, giving, as far as I remember at the moment, a history of syphilis contracted nine or eleven years ago. He was treated as an outdoor patient after being detained a couple of days for a spinal puncture—Wassermann positive. He was put on KI for a fortnight, and then attended weekly for "606" and Hg. The drug was given intramuscularly, and now, after five injections, he is walking much better, and has recovered the control of his bladder and rectum, is in good health, and looks much younger. This case demonstrates what could be done in the dispensary treatment of syphilis and by the intramuscular mode of treatment. He is continuing a long course of treatment. I think all cases of parasyphilis of the nervous system should be treated by "606" and Hg, even although at times the treatment seems to aggravate the symptoms. In these cases the treatment must be carried out with greater care in smaller doses, and for a much longer period, each case being treated on individual lines. Begin by giving a fortnight's course of KI and Hg, and then passing on to .1, .2, .3 grammes of "606," one dose weekly, till you have reached 4 to 5 grammes, allowing fourteen days' rest between each seven injections, and during that time giving KI.—*The Medical Press.*

# Editorials

## A BRITISH DOCTOR IN PARLIAMENT

One of the ablest members in the British House of Commons is Dr. Christopher Addison, elected as Liberal Member for Hoxton, in 1910. He has the double qualification of M.D., London, and F.R.C.S., England. He was for a time Lecturer on Anatomy at St. Bartholomew's Hospital, Hunterian Professor in 1901, and for some years Professor of Anatomy, University College, Sheffield. He had won the confidence of the people of Hoxton, a division of Shoreditch, by assiduous work for the poor, the sick and the children of the place. He suddenly found that he wished to be a member of Parliament "to have his share in doing good and resisting evil." Although he was a Liberal, Mrs. Humphrey, the fond mother of a very able Tory M.P., pointed out some time after he had been made Minister of Munitions, how, in that capacity, he was responsible for the management of a whole gigantic industry, with employees running into the millions, and managed it under conditions of humanity and forethought through his quick and sympathetic intelligence. He has recently been taken from the munitions and placed in a still more important position. The *Toronto Star Weekly* says: "Now as Minister of Reconstruction a monumental work devolves on him." It is nothing less than that of "laying the foundation of a new and happier Great Britain after the war."

## THE EXPENSE AND INCONVENIENCE OF QUARANTINE

It is well known by most physicians and a large number of citizens that quarantine frequently causes great inconvenience and considerable expense to those who are detained in their homes.

An excellent suggestion has been made in one of the lay papers of Toronto, which expressed the opinion that it would be a matter of simple justice if the City Council would make compensation for the losses which are thus so frequently borne by people who can ill afford the expense.

## MEDICAL FEES

The Compensation Board working under the Workmen's Compensation Act, Ontario, has issued a schedule of fees for "medical aid." The surgical fees range in part as follows: Amputations, $10 to $75; Fractures, $5 to $50; Dislocations, $5 to $25; Operations, $10 to $60; Administering anæsthetic, $5; X-ray, $3.50 to $10. Increased fees are allowed according to the circumstances, as for instance for multiple, compound or complicated fractures and dislocations; visits not included in other allowances, $1.50 to $2.50; office consultation, $1. These fees may be increased or decreased according to the nature of the injury, dressings required, and other circumstances; night visit, $1 extra; mileage, 50 cents one way outside town or city limits, but not exceeding $10. Fees higher than those specified in

any part of the schedule will be approved when circumstances warrant. Consultation fees allowed only when specifically authorized or approved by the Board. The schedule is operative from March 26th, 1918. It has the interim approval of the Executive Committee of the Ontario Medical Council, pending the next regular meeting.

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## THE VERSATILITY OF THE HUN

The admirers of everything German in years past used to refer to the remarkable versatility of the Hun—though they didn't call him by that name. At a recent patriotic rally in Philadelphia, held under the auspices of various medical organizations, it was generally admitted that the Germans had already gained distinction in one way, and that they keep piling up brutality on brutality, evidently determined to win the blackest possible page in history. Dr. Goodwin (Captain), of England, said in part:

"I was talking recently with a lady from New York who asked me if I hated the Germans. I replied that my feeling is one of utter detestation and horror of German methods. She said she hoped that as soon as the war was over I was going to forgive and forget. I said, 'No, I am not. I would like to, but it would be impossible,'" and told this story as one of the experiences that rankles in his soul:

"Two men were in the hospital, each with a fractured thigh. They were of different regiments and had never seen each other before. They were placed in beds alongside of each other, and they struck up

a tremendous friendship. Both were Englishmen, both married men with families.

"One morning, when a convoy was being sent across the Channel, word came at the last moment that one more patient could be taken. I said to these men, 'I can send one of you this morning.' Both looked across the Channel; there was a clear sea; both had been looking forward to going. Then one said, 'Well, I am not feeling quite so well; I don't think I will go this morning.' The other fellow said, 'If you don't mind, I would rather go another time.'

"I thought more of them than ever. We waited three or four days for another boat, and then sent them off on cots alongside each other on the hospital ship. I have never seen schoolboys returning from their sports in greater spirits than those two men. The ship was sunk by a submarine before reaching the other side. Sixty-three patients were on that boat whom I had been looking after for weeks. You know how much I feel like forgiving."

Let us quote in this connection from Dr. George W. Crile, of Cleveland: "The hospital in France which I had the honor to serve had been in existence for three years. That the enemy knew it was a casualty clearing station was obvious from the fact that on the map of a pilot who had been shot down the hospital was marked as such. On the night when our hospital was bombed four other hospitals in our territory and three or four French hospitals further down the line were bombed. The next night six other hospitals were bombed. Over 200 people were killed and wounded on these two nights. At the time of the bombing of the hospitals the German prisoners were the only ones who cried out. They

supposed the British were shelling the hospital, and when they were told that it was their own aeroplanes which were bombing the hospital, they cursed their own people as only the Germans can curse and hate. So far as I could see, every German prisoner of the British has been well cared for."

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# Editorial Notes

## CHILDREN AND TUBERCULOSIS

At the annual meeting of the Samaritan Club at Toronto, Dr. Dobbie, of Weston, spoke regarding the transmission of tuberculosis from one person to another. The adult, he said, does not contract tuberculosis from another by casual contact, but only by prolonged contact, accompanied by gross carelessness. Children, however, very easily contract the disease from an adult by a merely casual contact, and the younger the child the greater the danger. If years ago all little children had been removed from sources of contagion there would not be so many young people of twenty-five to thirty suffering from tuberculosis now.

No child should be allowed to live in a home where there is a case of tuberculosis, either the sufferer or the child should be taken out of the home, and if this is not done now, from every such case we will have, twenty or twenty-five years from now, another case of the same disease.

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## UNIVERSITY OF TORONTO—RECENT GRADUATES

The following have passed the 5th year examination in the University of Toronto, and are entitled to the degree of M.B.: G. H. Agnew, W. S. Aitchison, J. A. Alton (medicine and clinical therapeutics); C. H. Archibald, O. F. Banting (medicine and clinical oto-laryngology); W. B. Barnes (clinical medicine); W. H. Batten, G. A. Bentley (medicine); C. E. Ben-

well, W. P. Boles, C. E. Bond, Miss G. L. Boyd, Miss M. Bray, C. C. Brown, Miss M. A. C. Bulmer, R. F. Cain, V. Carlisle, B. Cohen, J. C. Copp, A. E. H. Couch, E. G. Coulson, M. A. Cox, R. F. Cromarty, W. H. Cunningham (medicine, surgery and clinical therapeutics); R. E. Dalton (aeg.), L. C. Edmonds, J. R. L. Eede, I. H. Erb, G. R. D. Farmer, H. Feader, C. A. Findlay, R. J. M. Fleming (clinical therapeutics; L. R. Gamey (medicine); C. T. P. Garbutt (clinical medicine); W. A. S. Geddes, W. Harris, W. J. Henry, A. B. Holmes, W. H. Holmes, J. V. Hughes (clinical therapeutics); H. O. Jones (medicine and clinical medicine); R. B. Kennedy, W. R. Lane (medicine, surgery and clinical oto-laryngology); F. S. Lazenby, J. W. Leach, S. C. Leonard, I. M. Lloyd, H. W. B. Locke, D. M. Low, G. J. Lunz (clinical medicine, obstetrics and gynæcology, clinical therapeutics); R. H. Malyon, Miss F. M. Meader, F. R. Mitchell, D. McCallum (clinical medicine); J. H. C. McClelland, J. T. McCosh (clinical therapeutics); J. D. Macdonald, D. W. McKay, H. J. McNally, F. P. McNevin (medicine, surgery and clinical therapeutics); A. W. Macpherson (surgery); J. H. Nesbitt, E. Nettleton, T. Owen, W. R. Parks, D. Perlman, D. V. Pratt, W. S. Quint, R. W. Rankin, O. C. Riseborough, J. M. Robertson, L. C. Rymal (clinical medicine and clinical therapeutics); W. J. Scott, M. Siegel, J. W. Sinclair, J. R. Smith, Miss L. H. Snider, M. H. Soules, R. J. Spence, B. G. Stephenson, G. H. Stevenson, J. G. Strachan, H. W. Street, L. M. Stuart, H. Sullivan, N. F. Tomlinson, R. M. Tucker (medicine and clinical therapeutics); A. W. Valens (clinical medicine and clinical therapeutics); O. Van Etter, L. Wagner, F. N. Walker, W. A. Werden, S. E. T. West.

W. H. Cunningham is granted aegrotat standing in the subjects of obstetrics and gynæcology and ophthalmology.

R. W. Simpson is granted aegrotat standing in the subjects of the fifth year.

J. V. Hughes has passed in the subject of medical jurisprudence, fourth year.

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## ENGLAND AND THE WAR

London has not passed through an Easter week such as this for many a century. The details of fierce fighting, the hopes, the fears, the need for courage and endurance and strength, have tested us as a people.

Three movements have taken place in England during the last few days. Those holding responsible posts at the front, who were here on leave, naturally hurried back as soon as news of the great offensive came. The wounded are coming in. There has been a quickening of effort throughout the country. The women cleaners in one institution in North London threatened to strike because they were given fish three times a week. They were in a very ugly temper indeed, and did not hesitate to show it. Then came the news of the battle and the arrival of the wounded, and the women got together and decided that they would eat fish six days a week if it were necessary for the nation's good. The trouble with them was over. This kind of thing has been going on among great and small alike. Our troubles of yesterday are too small and too petty to think of to-day.

### Waiting for the Wounded.

One of the most heartrending scenes in London nowadays is the assembly of the crowds around Charing Cross when the wounded arrive from France. Many of the people have come thinking that maybe their own kith and kin are there. We have mothers looking for sons, wives gazing for husbands. Some of them come day after day—standing still, craning their necks to see every face in the convoy. The crowds want to cheer. They want to throw flowers, sweetmeats and cigarettes into the ambulances. The authorities have had to issue a notice asking them to be quiet and not to cheer. These are wounded men; they have had excitement enough crossing over. It is necessary to keep them still now. And so cheers are hushed and only a sympathetic murmur goes through the throng.

At each of the great stations where the ambulance trains unload there are groups of canteen workers in uniform—usually a very pretty uniform—who go from cot to cot and from man to man distributing comforts under the direction of the nurses—coffee, cigarettes, and biscuits. The men are very grateful. The smokes and the hot drinks come as a great comfort to them, and they are not ashamed to show how touched they are at being remembered.

### Victims of War.

What are the feelings of the men who come back wounded from battle? My business obliged me last autumn to see wounded men at practically every stage from the front to London. I was with them when the "pineapples" from the Ger-

man trenches near by maimed them. I was in the field dressing station where the wounds were rapidly sterilized and bound up, and something given to ease the pain. I was on the hospital trains and at the wharfside at Boulogne as they embarked, and at the countryside in England where the trains stopped. Then I accompanied them to the hospital.

The feeling of most wounded men after the first excitement is over is one of almost incredible exhaustion. The physical blow has taken away their strength; the blow which one lad I know fittingly compared to a kick from an elephant's hind leg. With this feeling of exhaustion there is not unnaturally a feeling of relief. The man knows the worst; he can rest. Often enough in battle he has not been resting for days before he was wounded.

Please do not imagine that the mood of London at this moment is one of fear or depression. It is nothing of the kind. There is a tense electric feeling in the air. There is a hardening of the public temper and a determination among all classes to strengthen our arm and increase our power.

One of the most striking signs of the times is the enormous increase in uniformed women to be seen in London. The khaki woman becomes every day more and more familiar. Last night I saw a company of them marching by my window in proper military formation, without swagger or show, just soldier women doing army work. Three years ago, when the war was in its early stages, some women pioneers who then began to organize and drill women, were asked of what use they thought this would be. "The time will come," said one of them, "when your sources of man-power will become more or less exhausted, and then you will want women to drive your ambulances and bring back the wounded, and to do all the work of the base." At that time it seemed to many of us a somewhat absurd forecast. To-day it is a commonplace fact.—*Wanderer, April 6th, 1918, Daily Mail, London, Eng.*

# News Items

The Minister of Militia, in an address delivered at Hamilton, April 21st, stated that up to that date about 30,000 Canadians were killed and 106,000 wounded.

The annual meeting of the American Public Health Association for 1918 will be held in Chicago, October 14-17, under the Presidency of Dr. Chas. J. Hastings, Toronto.

A new wing has been added to the College Street Military Hospital, Toronto, with accommodation for 22 beds. The new ward is intended for the neurological patients of Capt. Fletcher, C.A.M.C.

At the recent meeting of the Association of American Physicians, held in Atlantic City early in May, Dr. A. McPhedran, Toronto, was elected President, and Dr. C. F. Martin, Montreal, was elected a member of the Council.

Sir Sam Hughes, in the House of Commons, May 2nd, asked if, in view of the scandalous situation existing in the medical service in England, it was the intention of the Government to reinstate Col. Herbert Bruce, M.D., of Toronto. Sir Robert Borden, in reply, stated that he had no knowledge of such a situation existing, and so far as he was able to say, the services were never better.

There was great rejoicing in the Canadian House of Commons when it was announced May 13th that the Hon. Dr. Beland had been released by the Germans, and was then in Holland. Just before the outbreak of the war Dr. Beland was married to a Belgian lady. He was on his honeymoon trip in Belgium at the time of the German invasion. Although he could easily have got away, he remained to give aid to the German and Belgian wounded. The Germans rewarded him by making him a prisoner. While a prisoner, his health suffered seriously. About a year ago his wife became ill in Belgium, and shortly afterwards died. The German authorities refused to allow him to go to visit her during her illness.

It is said there are seven hospitals in the world associated with Women's Medical Colleges. The hospital established some years ago by the Women's Medical College of Toronto has done excellent work with its limited accommodation of only 13 beds. Efforts are now being made to enlarge the building so as to accommodate 34 beds.

Probably no visitor from England was more cordially received in the United States and Canada than Col. Goodwin of the R.A.M.C. He came to Toronto especially to visit the Connaught Laboratory, and was very highly pleased with everything he saw there. His friends on this continent were very much delighted when they heard of his promotion to the position of Director-General of Medical Military Matters. Col. Goodwin succeeded a very popular and efficient officer. Col. Goodwin took charge March 1st, 1918. The medical journals and the lay press in Great Britain are very enthusiastic, praising both Sir Alfred Keogh and Goodwin. *The Hospital* of January 19th speaks of Colonel Goodwin as a most tactful, kindhearted, willing and helpful man, who in the past has been, and is now, worshipped by the men under him. We learn from Major Fitzgerald that Goodwin is now Lt.-General Goodwin, there being only two higher ranks in the army, General and Field Marshal.

Lt.-Col. H. R. Casgrain, C.A.M.C., of Windsor, Ont., is still in command of No. 8 Canadian Hospital, which is located at St. Cloud, near Paris. This hospital was presented to France by the Canadian Government, soon after the commencement of the war. Col. Casgrain considers himself very fortunate, because the distinguished surgeon, Dr. Carrel, who has done so much admirable work since the war began, has installed his laboratory in this hospital. Col. Casgrain, in his letters, refers eloquently to the magnificent spirit and courage of the Allied soldiers in the present German offensive. He writes, in part, as follows: "They have stood firm against overwhelming odds, against weapons more terrible than the past ever knew; they have faced death from air crafts, from poisons in the air that choke and burn, and they make a living rampart of their bodies against liquid fire. The magnificent self-sacrifice, courage and devotion, manifested by our men in the present German offensive, which has been raging for the past twenty-one days, is ringing in the ears of every man, woman and child in the

Empire. Such wonderful courage, such glorious tenacity, has never before been shown in history. With such splendid men, animated with such splendid spirit, peace with victory cannot be far off."

Maj. J. G. Fitzgerald, M.D., left Canada in March, reaching Glasgow April 3rd, and the following day went to London. He there met Gen. Goodwin and Maj. Smales, both of the R.A.M.C. Finding that he could get over to France sooner as a pathologist than as a sanitarian, he at once joined the laboratory staff and signed for one year with the British Medical Corps. He was detailed to the London area, and was sent for two weeks to the Central Cerebro-Spinal Laboratory, which is conducted by Lt.-Col. Gordon, R.A.M.C., who is pathologist at St. Bart's in peace time.

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## NURSE EDITH CAVELL

(*Two o'clock the morning of October* 12, 1915).

By Alice Meynell.

To her accustomed eyes
The midnight-morning brought not such a dread
As thrills the chance-awakened head that lies
In trivial sleep on the habitual bed.

'Twas yet some hours ere light;
And many, many, many a break of day
Had she outwatched the dying; but this night
Shortened her vigil was, briefer the way.

By dial of the clock
'Twas day in the dark above her lonely head.
"This day thou shalt be with me." Ere the cock
Announced that day she met the Immortal Dead.

# Personals

Lieut.-Col. Leask, C.A.M.C. (M.B. Tor., 1899), has received the D.S.O.

Lt.-Col. R. M. Simpson, Winnipeg, was recently promoted to the rank of Colonel.

Capt. Wm. E. Jones, C.A.M.C. (M.B. Tor., '16), is now at the Risbow Barracks, Shorncliffe.

Dr. Helen MacMurchy has been elected President of the Woman's Canadian Club, Toronto.

Lieut. Spohn, R.A.M.C. (M.B. Tor., '10), is now on the staff of the London (England) Military Hospital.

Dr. Alfred Caulfield is now living at 13 Spadina Road, Toronto, and has resumed his work in the University.

Dr. Winnifred Cullis, who spent the months of March and April in Toronto has returned to her home in England.

Col. Jno. Amyot, C.A.M.C., of Toronto, was in London, England, when last heard from, and was said to be very well.

Rev. O. L. Kilborn, M.D., has been appointed Secretary-Treasurer of the Methodist Mission in China.

Dr. Wellington Adams, for many years a prominent dentist of Whitby, died at the residence of his son, Dr. Allan Adams, 335 Jarvis Street, Toronto, aged 70.

Dr. Thos. E. Case (Vict. '83), of Dungannon, was elected by acclamation as M.P.P. for North Huron, in the place of Mr. A. H. Musgrave, resigned.

Dr. J. A. Harvey (M.D., Victoria '85), of Orillia, has three sons serving at the front, all of whom are university men, two being graduates in Medicine.

Capt. D. M. Warren has been transferred from the R.A.M.C. to the C.A.M.C., and is now on the staff of the Canadian Red Cross Hospital, Bushy Park, Hampton Court.

Capt. Philip Garratt, son of the late Dr. Alton Garratt, Toronto, was made commanding officer of a bombing squadron near Cambridge, England, April 10th.

Capt. Ed. Gallie, C.A.M.C., and five Canadian M.O.'s, reached London, April 5, and were at once sent to Shorncliffe for one month's training at the depot.

Lieut. Frank Dales, of the Royal Field Artillery, son of Dr. J. R. Dales, Dunbarton, Ontario, was rather seriously gassed near Arras during the big drive.

Capt. Robert S. Armour, R.A.M.C. (M.B. Tor., '15), Campbellford, Ont., has been mentioned in despatches for meritorious work in East Africa. He is at present C.O. of a base hospital in East Africa.

Lieut. Alan A. McLeod, a son of Dr. Alex. N. McLeod, of Stonewall, Man., has won the Victoria Cross. As a member of the Flying Corps, he received his first training as a cadet in Toronto. He left for overseas in August, 1917.

Hon. Dr. Roche went from Ottawa to Toronto May 15, and on the following day went on to London, where, as Chancellor of the Western University, he presented the degrees at Convocation.

The Military Cross has been awarded to Capt. Dimrock Cassidy, R.A.M.C., of Winnipeg, Manitoba. He went down in a mine shaft where men were gassed and remained all night, rendering first aid, although for a portion of the time he was seriously affected by the gas himself.

Capt. Gordon W. Armstrong, who saw service with the R.A.M.C. in France and Mesopotamia, recently received the D.S.O. The distinction was granted for working in the open under continuous shell fire, giving aid to the wounded, and also for going to the aid of an officer and orderly, and carrying them from the danger zone. He graduated B.A. from Victoria and M.B. from Toronto in 1916.

Capt. H. J. Watson, formerly in the C.A.M.C., had been appointed Major in the United States Medical Reserve Corps. He is a graduate in medicine of Trinity University, and also is an M.D. from the University of Manitoba.

One of the most interesting incidents at the Convocation of the University of Toronto was the presentation of the Diploma of Public Health to Lt.-Col. Geo. G. Nasmith, C.M.G., who, as everybody knows, did magnificent work for the allies in France and Flanders.

General G. Sterling Ryerson, M.D., Toronto, spent the last week of April in Seattle, Washington State. He expected to leave for California, where he intended to deliver a number of addresses, the tour to last about a month. He then expected to go to one of the watering-places on the Pacific Coast for a few weeks.

Capt. Edward Ryan, C.A.M.C., Superintendent of Rockwood Hospital, Kingston, now on military service in Toronto, was recently entertained by the Rochester Medical Association. He delivered an admirable address, which was highly appreciated by the profession of Rochester.

Dr. Horace Legault, who has been practising medicine for some time in Ottawa, was tried May 9th on a charge of having attempted to bribe Capt. Andrew Davies, M.D., a member of the Army Medical Board. Dr. Legault pleaded guilty, was fined $500, and sentenced to one day in jail.

Col. Geo. Armstrong, the well-known surgeon of Montreal, returned to that city May 1st, after spending a year and a half with the C.A.M.C. We are glad to report that Col. Armstrong is well, and speaks in very high terms of the work which has been done, and is now being done by both the British and Canadian Medical Corps.

# Obituary

## MAJOR ALLAN D. POWELL

The citizens of Ottawa were deeply grieved when a cablegram reached that city, April 21st, announcing the death of one of her most popular citizens and one of her best all-round athletes, Major Allan D. Powell, D.S.O., son of Dr. R. W. Powell, from wounds received April 19th.

## NICHOLAS D. RICHARDS, M.D.

Dr. N. D. Richards died at his home in Belleville, April 18th, after being ill for some time with heart disease. He graduated M.D. from Toronto University in 1877. He immediately settled in Warkworth, where he practised until 1911, when he removed to Belleville. He had a large practice in East Northumberland, and for many years was one of the most prominent workers in the Conservative party. Dr. Richards at present practising in Warkworth is a son.

## O. M. JONES, M.R.C.S.

Dr. O. M. Jones, one of the most prominent surgeons of Western Canada, died at his home, Victoria, B.C., March 14th, after a short illness from pneumonia, aged 59. He was a prominent member of the Canadian Medical Association, and also the American Association of Railway Surgeons.

He was well known in Toronto, which place he frequently visited, and being while there generally the guest of Dr. Bruce Riordan.

## PATRICK ROBERTSON, M.D.

Dr. P. Robertson, formerly of Canada, but in recent years a practitioner in England, died at his home in Caversham, England, April 9th. He graduated M.D. from McGill University in 1864.

Mrs. Ault, widow of the late Dr. Ault, of Acton, died at Tillsonburg, April 16th.

# Book Reviews

*Clinical Lectures on Infant Feeding.* By Lewis W. Hill, M.D., Children's Hospital, Boston, and Jesse R. Gerstley, M.D., Michael Reese Hospital, Chicago. 12mo. of 377 pages, illustrated. Philadelphia and London: W. B. Saunders Company. 1917. Cloth, $2.75 net. Canadian Agents: The J. F. Hartz Co., Toronto, Ontario.

This book represents something new in medical education, for it consists of courses of clinical lectures given under the auspices of the Board of Health of North Carolina, by travelling lecturers, bringing post-graduate instruction to the physician's own door. Probably the greatest public health problem to-day is the restriction of infant mortality. Faulty feeding methods, directly or indirectly, are responsible for by far the larger percentage of such mortality, and education directed along such lines ought to be one of the best methods of attacking the problem. Two schools of pædiatric teaching are represented —Boston and Chicago—although the reviewer fails to see any marked difference of opinion between the two. The subject matter considered is that of breast and artificial feeding, the various types of difficult feeding, the digestive and metabolic disturbances of infancy. Both writers devote one lecture to practical clinics. The book makes interesting reading and should be of particular interest to the general practitioner.

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*A Clinical Manual on Mental Diseases.* By Francis X. Dercum, M.D., Ph.D., Professor of Nervous and Mental Diseases, Jefferson Medical College, Philadelphia. Second edition, revised. Octavo of 497 pages. Philadelphia and London: W. B. Saunders Company, 1917. Cloth, $3.50 net. Canadian Agents: The J. F. Hartz Co., Toronto, Ontario.

The object of the author was to give a purely clinical presentation of the subject, useful not only to students, but also to the general practitioner who wishes to keep abreast of the times. In classification at any rate, psychiatry has changed

a good deal during the last decade, and many of the terms used are entirely new. As the family physician is most often the first to see the patient, it is necessary for him not only to recognize the early symptoms of mental disease, but to understand the modern nomenclature. This volume admirably fulfils its intentions.

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*International Clinics.* A quarterly of illustrated clinical lectures and especially prepared original articles, by leading members of the medical profession throughout the world. Edited by H. R. M. Landis, M.D., Philadelphia. Vol. IV., twenty-seventh series, 1917. Philadelphia and London: J. B. Lippincott Company.

This volume continues the series of practical clinics begun a year ago, which have made this quarterly of such great value. The articles of general interest, however, have not been neglected, and one finds a number relating to war-time problems.

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*Canadian Medical Directory.* Containing the law of the reciprocity of license between the United Kingdom and Canada; the regulations of the Medical Council of Canada, with list of licentiates; the medical societies, hospitals, etc., of each province; the laws and regulations for the practice of medicine, surgery and midwifery, in the different provinces. With complete alphabetical index of physicians of the Dominion. First edition. Price, $3.00. Edited by N. W. Moore, M.D., 6456 St. Mary Street, Montreal, 1918.

# Selections

## The Use of Hormone Equations in Acute Infectious Diseases

Carpenter, in *Medical Record*, points out that organotherapy has made great strides in the last twenty years, but the bulk of experience has been in its application to the treatment of functional and chronic diseases. Latterly much attention has been given to the study and treatment of organic disease of the ductless glands, and so absorbing has become this interesting and important study that the possible use of hormone therapy in acute infectious diseases has been almost overlooked.

The one great source of immunity from disease is within the body and not outside of it. Until very recently it was the prevailing opinion among those who thought enough about it to have an opinion that the source of immunity and resistance to disease lay primarily in the leucocytes. Such a position is entirely untenable. In the nature of things whatever powers the leucocytes have must be conferred upon them by the organs that produce them. And it is well known that the action of the plasma is due to the antibodies contained in it.

But if the presence of antibodies in the plasma determines its effectiveness in combating disease, it becomes a very important matter to determine what these antibodies are, and especially their origin.

There is ground for belief that the antibodies and the hormones are identical. If this is true, there is but one conclusion that can be drawn and this is the third and most important proposition to be stated: The endocrine organs constitute the defensive mechanism of the body. If this is true, then it is clear that by the administration of those organs or their products, we should be able to prevent disease by increasing the body resistance at will; and in cases where disease has already become established in the body, we should by the same means be able to restore it to normal.

It is not claimed that hormone equations have been constructed for all infections. Only a very small number out of the many that have been tried have proved specific, but enough, it is thought, to prove the truth of the principles involved.

The infections in which practically specific effects have been produced are pneumonia, acute pneumonococcic laryngitis, ery-

sipelas, some pus infections, puerperal sepsis, measles, scarlet fever and dysentery, both amœbic and bacillary.

Although they cannot be classified as acute infectious diseases, it is just as well to mention, in this connection, carcinoma and sarcoma. Two cases of the former and one of the latter have quickly disappeared under treatment and have not returned. Epithelioma strangely enough has not yielded to the same hormone equation, but it is thought that a slight change in the proportions may fulfill the indications and produce a similarly happy result.

Some hormone equations, while markedly specific when given subcutaneously or intramuscularly, do not give comparable results when administered internally. The effects are either much diminished or even wanting.

At this particular time, when large numbers of men are being brought together in army camps where they are susceptible to acute infectious diseases, it is important that the possibilities of this specific treatment be recognized and made use of. —*American Medicine.*

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## Shock

This, one of the major problems of war, has been subject to an intensive study upon the part of clinicians and laboratory men. Although it is probably true that no revolutionizing treatment has been discovered, there has been a certain formulation of methods long since recognized as of wide application, and a rejection of drugs regarded as distinctly hurtful by surgeons who have given the matter careful study. Thus in all the contributions it is noteworthy and most gratifying to find an active absence of combinations of strychnine, camphor oil, atropine, or other alkaloids, and a general agreement as to the value of morphine when shock is attended by severe pain or great restlessness without dyspnœa. There is universal agreement as to the beneficial effects of rest, quiet, external heat, and head in low position; a not unanimous verdict as to the value of normal salt solution, Ringer's solution, hypertonic salt solution, and bicarbonate of soda; one or two voices strongly raised in favor of rebreathing, forceful breath, and $CO_2$; a universal recognition of the value of transfusion as a means of raising and maintaining blood-pressure at the increased level.

It is interesting to note that in the report of the Special

Investigating Committee appointed by the Medical Research Committee of Great Britain in August, 1917, to undertake the co-ordination of inquiries into surgical shock and allied conditions, with a view to a better correlation of the laboratory and clinical observations (*Journal of the American Medical Association*, February 23, 1918). Fraser and Cowell have devoted themselves for over two years to the reading and recording of blood-pressures in a variety of wound conditions. They report satisfactory results from the intravenous use of hypertonic solution, consisting of sodium chloride 2 grammes, potassium chloride 0.05 gramme, calcium chloride 0.05 gramme, and water 100 Cc.

They also secured pressure which was maintained by the injection of calcium chloride 0.075 gramme; sodium chloride 1.325 grammes; gum acacia 2 grammes; water 100 Cc.

Fraser and Cowell have changed this slightly, giving less sodium chloride and more calcium chloride, and leaving out the potassium salt entirely. They record good results from the use of 15 to 20 or even 30 ounces of the solution, given intravenously. The solution was given slowly, at the rate of five ounces in five minutes, and its heat maintained at a temperature of about 120° F. in the reservoir. It was repeated if necessary in twelve to twenty-four hours.

Direct blood transfusion, as could be expected, caused an immediate and persistent rise of pressure. As to heart drugs, such as pituitary solution, epinephrin, caffein, camphor, etc., the authors state there is not sufficient evidence to show that one of these drugs takes precedence over the others. They conclude their paper by commending direct blood and calcium hypertonic gum solution injections. Physiological sodium chloride solution is regarded as unsatisfactory. They also hold that the observation of pressure during the first weeks of convalescence affords an excellent index as to the prognosis, steady rising or maintaining of high pressure being of course favorable.

Cannon, Fraser and Hooper have particularly studied the alterations in the distribution and character of blood in shock and hæmorrhage. They regard a high capillary red count as the first noteworthy characteristic, particularly noteworthy since hæmorrhage so often complicates the war cases. A 7-per-cent. solution of gum acacia in sodium chloride solution, as advocated by Bayliss, raised the blood-pressure in shock, but lowered both the blood count and the hæmoglobin, as might be

expected. Hypertonic saline injections distinctly rapidly lowered the high count of the capillary blood. Coincident with this there was a drop in the hæmoglobin. The authors regard the continued concentration of the peripheral blood as of evil prognostic note, as is also a continued dilution of the blood beyond the fourth or fifth day after injury.

Cannon contributes a valuable paper upon the occurrence of acidosis in shock, hæmorrhage and gas infection. All these cases have a diminished supply of available alkali in the blood; the lower the pressure, the more marked the acidosis. The pulse is rapid, but does not vary with the degree of acidosis. The respiratory rate becomes more rapid as the acidosis increases, until shortly before death a true air-hunger may prevail. This acidosis is not due to lack of circulating carbohydrate. It should be noted that operation on men suffering from shock and acidosis results in serious and rapid sinking of arterial pressure when it is already low, and in marked and sudden decrease of the alkali reserve of the blood when that reserve likewise is already low. This change may not occur if nitrous-oxide-oxygen anæsthesia, instead of ether, is employed, but that anæsthetic affords no guarantee against the ominous decline.

Cannon states that shocked men suffering after operation from extreme acidosis with "air-hunger" can be quickly relieved of their distress by intravenous injection of solution of bicarbonate, and their blood-pressure restored to normal.—*The Therapeutic Gazette.*

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### Treatment of Peptic Ulcer

Writing in the *New York State Journal of Medicine*, Kast points out that first of all it is necessary to be clear as to which cases should be treated medically and which should not. Kast groups his patients as follows:

*A. Surgical without delay* are cases of

1. Perforated ulcers.

They should be operated upon as soon as possible. If a delay of more than forty-eight hours has occurred; if there is no general peritonitis, and the situation seems safe, it becomes a matter of choice. Surgical experience, as well as his own, would indicate that it is better then to wait with the operation until the perforation is well walled off.

2. Repeated serious hæmorrhages, particularly with continuous occult bleeding in chronic or recurring ulcers.

*B. Surgical as soon as feasible:*

1. Chronic ulcers which had the chance of one or two systematic rigid medical treatments—by which we understand, aside from other factors, four weeks in bed, and at least two months longer on an appropriate planful dietetic course.

2. All indurated ulcers, particularly with pyloric stenosis, or ulcers with disturbing adhesions.

3. Penetrating ulcers and hour-glass contractions.

4. Cases of intractable continuous secretion.

5. All cases which offer suspicion of malignancy.

*C. Border-line cases:*

1. Cases in which a medical cure becomes doubtful because of difficulties in giving up the time for treatment in bed and inability to carry out the proper diet and rest afterwards.

2. Cases of peptic ulcer complicated by severe neurasthenia, particularly those which become dependent upon anodynes.

To claim all cases should be treated medically as long as possible is as extreme and foolish as to claim all cases should be operated upon as soon as the diagnosis is made. The extremists do not help but retard the growing understanding between surgeons and medical men. It is not the question which is the cure-all, but to learn by conservative exchange of our experiences to select, as early as possible, the cases which should be surgical and those which should at least, for the time being, remain medical. But Kast must confess that to his judgment a great many medical men persist in wasting time and good chances for the patient with ill-conceived and haphazard plans of medical treatment. On the other hand, the poor results from bad medical treatment are not an argument for surgery but for better medical treatment.—*The Therapeutic Gazette.*

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## Obstetric Fads and Heresies

In the *Medical Record* of December 8, 1917, Grandin writes on this topic in an entertaining way. The first fad he notes is the so-called "twilight sleep." Emanating from that land of myth and fiction along the shores of the vine-clad Rhine, it was introduced into America properly labelled, like other German patent medicines and tinware and matches. The American endorsers chose a popular magazine for advertising purposes,

and women cried for it and professors boosted it! Like the moth, the Lord be praised, it has died the death to which, for the nonce, all things Hun are doomed, and to-day Grandin cannot find a single practitioner of repute who uses the method. Why it ever gained foothold passes his comprehension, unless the profession, sated with old-time methods of repute for allaying the anguish of child-bearing, is, like the Greek, hunting for a new god. Buckingham and Reynolds and their pupil Richardson taught Grandin a better method, and a method which does not carry a mortality-rate, nor an infantile death-rate, such as, on investigation, will be found associated with twilight sleep. In the fourth edition of his "Practical Obstetrics," Grandin analyzed the statistical data culled from German sources, and he showed that these data damned the method. Grandin says: Avoid, medical brethren, the folly of extremes, and hold fast to that which is good. Use chloral freely, and be not afraid; resort to morphine and atropine with judgment; administer quinine judiciously after the contractions are well under way; be not afraid of chloroform; do not delay the application of the low forceps after a timely fashion. Thus you render labor as nearly painless as our present knowledge permits, without subjecting woman or child to the dangers inevitably associated with the use of morphine, hyoscine, or scopolamine.

The next fad Grandin notes is the Cæsarian-section craze. It was his fortune to perform the early Cæsarian sections from an elective standpoint; that is to say, under the elective indications, in 1889-1890. His thesis for membership in the American Gynæcological Society bore the title, "A Plea for the Cæsarian Section from an *Elective* Standpoint." After the lapse of twenty years, with the experience thus gained, he can preach the same sermon to-day. *Festina lente*, obstetric friends! he exclaims. To show the extremes to which certain rabid Cæsarian sectionists will go: A number of years since an assistant of Grandin called on him, greatly perturbed because a professor had advised the section on his wife for the reason that in the previous labor she had suffered from uterine inertia! The pelvis was normal, the presentation L. O. A. Grandin quieted his young friend, ordered strychnine, gr. 1-40 t. i. d. for six weeks precedent to labor; when the contractions became active, chloral in 15-grain doses every three-quarters of an hour until 60 grains had been administered; quinine, 15 grains at one dose. In fourteen hours the woman delivered herself of a splen-

did boy weighing 13 pounds. The woman has no scar on her belly; she did not run the modest 4-per-cent. risk associated with the Cæsarian section; the professor was unable to notch his Cæsarian-section rod. Grandin has carefully analyzed the series of sections recorded by a number of operators, and it's "dollars to doughnuts" that Tarnier or Isaac E. Taylor, if alive, could cut the series at least 30 per cent. Grandin wonders if some of these operators are trained in the technique of version, if they own the axis-traction forceps, if they have relegated the induction of premature labor to the ash heap!

Another fad is this question of birth control. This question need never have arisen. In his professional career Grandin has never hesitated, after due consultation, to induce abortion where otherwise the life of the woman was imperilled. This course he will continue to follow. So far, he has escaped Sing Sing, although, possibly, according to a certain religious belief, he may spend a few years in purgatory. If so, he will certainly find very congenial company. The daily press—sometimes to the exclusion of war news—has exploited this advance guard of woman suffrage. To the medical press Grandin would say that neither man nor woman should be entitled to procreate more children than they can rear. The doctrine he preaches is not that of birth control, but that of *sex repression*. Neither man nor woman should be allowed to make animals of themselves, and Grandin apologizes to the animals in remembrance of the fact that they are continent except during the rutting season. Followed to its logical limit, "birth control" allows men and women to copulate without sanction of law or clergy. The woman will "sin" all the more frequently because of lack of fear of the consequences. The man will remain the same rascal he has been, sexually, since in the garden of Eden Adam laid the blame on Eve.—*The Therapeutic Gazette.*

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### Radium Therapy in Uterine Cancer

Stone, in *Amer. Jour. Obstetrics and Diseases of Women and Children*, regards the use of radium in the treatment of uterine cancer as of definite service.

1. It is an agent peculiarly suitable for the treatment of uterine cancer, and is more effective for the arrest of the progress of the disease, as it is ordinarily presented to the clinician, than any other method that has hitherto been employed.

2. It is more effective in primary lesions than in recurrences.

3. It will occasionally relieve pain in the terminal stages of the disease.

4. It will relieve pain, stop haemorrhage and discharge, and restore the general health in a large number of advanced lesions more effectively than any other agent.

5. It will convert borderland lesions into such as are plainly operable and without surgery it will effect a disappearance of the gross evidences of the disease and restore health in a large number of such lesions more effectively than surgery alone has hitherto been able to do.—*American Medicine.*

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**Case of Keloid.** By S. E. Dore, M.D.

I have brought this case for diagnosis. This young woman says she had ulcers on both shins seven and a half years ago, and that they were preceded by a rash on the trunk. The ulcer on the right leg healed in fourteen months, leaving a healthy more or less circular scar, which is visible now. The sore on the left leg nearly healed in eighteen months, but a small "pimple" was left, and this gradually increased in size to the present time. There is now a raised button-like growth about the size of a shilling on the site of the scar of the left leg. The edges are well defined and without any "processes," the skin over the tumor is slightly thin and shiny but otherwise normal, and the growth is firm to the touch, movable over the underlying tissues, and does not show any evidence of inflammatory changes. As there is a scar in a corresponding position on the opposite leg, and a history of the tumor having originated in scar-tissue, I made the diagnosis of keloid, and I shall be glad of alternative suggestions.

With regard to treatment, I suggest radium, but it has just been suggested that the growth should be excised and microscoped. If it is a keloid, however, I doubt the advisability of excision, although I have heard it stated that if a keloid is sufficiently widely excised it does not recur.—*Proceedings of the Royal Society of Medicine.*

**Caffein has been found in the urine fifteen days after its administration had ceased. This establishes the question of the cumulative action of the drug, and explains why many of the foremost medical men of to-day stigmatize caffein as "treacherous."**

If caffein is "treacherous" in the hands of the skilled physician, when used as a drug, what must it be when taken steadily by people in irregular and large amounts, as a part of their daily meals?

What greater duty has the family physician than to warn his patients, sick or well, against the caffein-bearing beverages—tea and coffee? And what more rational and salutary habit can he advise than the regular use of the pure cereal beverage—

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Postum comes in two forms: **Postum Cereal**—the original form—must be well boiled. **Instant Postum**—the soluble form—is made in the cup with hot water—instantly.

Samples of **Instant Postum, Grape-Nuts** and **Post Toasties** for personal and clinical examination, will be sent on request to any physician who has not yet received them.

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**CANADIAN POSTUM CEREAL CO., LTD., WINDSOR, ONTARIO.**

P.—4

# Miscellaneous

## A Veritable Prop

After the subsidence of the acute symptoms of any serious febrile disease, an examination of the blood will almost reveal a degree of anæmia in direct proportion to the severity and duration of the primary disease. It is thus always desirable in such cases to adopt measures to revive, restore and reconstruct, and with this object in view one should begin at the foundation, i.e. the blood itself. To construct new red cells, and reconstruct those which have become dehæmoglobinized by disease, nothing is more potent in effect than Pepto-Mangan (Gude). This standard preparation of organic iron and manganese supplies the vital fluid with the elements needed to reconstruct and restore its oxygen-carrying capacity, by contributing the necessary hæmoglobin. Pepto-Mangan is palatable, absorbable, and promptly assimilable. It encourages the appetite without disturbing digestion or causing constipation.

---

## Sanmetto and Cannabis Indica

Cannabis indica fulfills two important indications. First in order of efficiency it is a remedy for depression of the nervous system. Secondly, it relieves pain in the irritated urino-genital tract. For the first purpose it is valuable in more or less painful conditions, in which opium, on account of its tendency to restrain normal secretions, would be inadmissible. Cannabis exerts far less restraining power over the secretions than does most similar anodynes, it favors good appetite and digestion, and exhilarates the spirits. Hence its value in such disorders as are attended by gloom and foreboding. It is perhaps in genito-urinary disorders of an inflammatory type that its usefulness is most strongly displayed. With sanmetto it meets the wants of a pain reliever and nerve soother in urethritis, whether idiopathic or specific. Sanmetto and cannabis are, perhaps, more frequently indicated than other internal agents in acute gonorrhœa. They are of great importance in surgical fever, due to the passing of the catheter or bougie, or from operations upon the urethral tract. Think of sanmetto and cannabis indica in chronic cystitis, chronic irritation of the genito-urinary

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This company was in fact founded to grant life insurance to persons below the average standard of fitness imposed by the ordinary life offices of that day. By its Act of Incorporation, eight of the Board of Directors must always be members of the Medical Profession. The long list of eminent physicians and surgeons who have served in this capacity is a recital of the leaders of the medical profession in Great Britain during nearly a century. Sir Richard Douglas Powell, (Bt., K.C.V.O., M.D., Physician in Ordinary to H. M. the King), is the present Vice-President of the Society.

It is upon the broad lines which this great company has proved scientifically and commercially successful, that the Empire Life Insurance Company of Canada purposes to proceed, and thus extend in the Dominion the protection of life insurance to a large class from whom it has hitherto been withheld.

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tract; burning micturition, and strangury. Note briefly the specific indications: marked nervous depression; irritation of the genito-urinary tract; burning frequent micturition; painful micturition, with tenesmus, and scalding urine. The dose of cannabis indica is ¼ to 1 grain, according to the susceptibility of the patient; sanmetto one to two teaspoonfuls.

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### Psychology

Lovat Fraser, in one of his references to the Huns, spoke as follows: "Over and over again in this war it has been plain that the enemy do not understand the psychology of the western Allies. They understood Russia only too well, but they fail to realize that they could not impose their terms on Great Britain and France even if the French Army was back on the Loire and the British Army was coming home on rafts."

---

### A Useful Local Anaesthetic

It is doubtful if any new remedial agent in many years has met with a readier acceptance by Canadian physicians and surgeons than is being accorded to Apothesine, the synthetic local anæsthetic recently announced by Parke, Davis & Co. The prompt appreciation which has marked the advent of this new product is gratifying for two reasons: Apothesine is an efficient and broadly useful local anæsthetic; it is a fruit of American enterprise and research.

Apothesine is described as the hydrochloride of gamma-diethyl-amino-propyl cinnamate. It occurs in the form of small snow-white crystals, having a melting point of 137°C. It is readily soluble in alcohol, slightly soluble in acetone and ether, and very soluble in water. If desired, it may be sterilized, in solution, by boiling, and it can be combined with any of the usual synergists.

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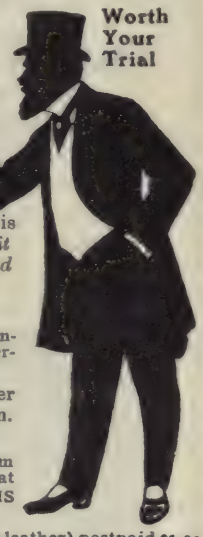

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Parke, Davis & Co. announce that they will be pleased to send literature on Apothesine to any physician or surgeon who is interested in the product.

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### The Medical Profession and the Insurance of Under-Average Lives

More and more attention seems to be turning each year to the insuring of sub-standard or under-normal lives, but at the time, there is comparatively little of this business being carried on, and then, only upon selected sub-normal lives. It would appear, however, that conditions arising out of the war are gradually lending their influence to this rather specialized branch of life insurance practice, with the result that more attention is being given the matter.

In view of this, it is therefore with considerable interest that one learns of the organization of a Canadian company—indeed, it will commence business within a few months—which will specialize in the assurance of sub-standard lives throughout the Dominion.

This company is the Empire Life Insurance Company of Canada, with an authorized capital of $1,000,000, made up of 10,000 shares of $100 each. The Head Office is located in the Bank of Toronto Chambers, Toronto.

The medical profession and medical advisers of life insurance companies undoubtedly are much more capable at the present time of offering an opinion as to the probable effects of certain diseases than they were some years ago, indeed there is little doubt that in many cases they have a very decided

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opinion as to the nature, extent and period of the extra mortality. In this connection the medical profession will prove of great assistance to this company.

The great necessity for adequate medical assistance in the selection of these risks will be fully recognized by the directors. Following the practice of the companies that have successfully specialized in this branch of life insurance, they are securing the co-operation of a strong advisory medical board. We understand that this medical board is now in course of formation, and in our next issue we look forward to giving the names of the medical officers of the company.

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### Sulphur in Psoriasis

Louis Bory (*Lancet*), describes a new treatment of psoriasis based on the relationship between this condition and tuberculosis. His formula is:—

| | | |
|---|---|---|
| Precipitated sulphur ..... | 0.20 gm. | gr. iii. |
| Eucalyptol ..... | 20.00 gm. | ℥ v. |
| Oil of sesame ..... | 80.00 gm. | ℥ iiss. |

The oil is warmed until the sulphur is completely dissolved, and the eucalyptol is then added. 5 c.c. (one dose) of this solution (=0.01 of sulphur) is injected deeply into the gluteal muscles. In one case a single injection caused large confluent patches, extending all over the body, to disappear in several days.—*The Prescriber.*

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### How Old Are Physicians?

During international strife, even more than in the piping times of peace, the physician and his service stand in a special class. In drafting the combatant forces the Government has limited itself to men between the ages of twenty-one and thirty-one years. It accepts volunteers to a somewhat greater age. But for the physician the age limit is raised to fifty-five years. There are special reasons for this. One is, of course, that the number of physicians required for military service in time of war is greatly beyond the proportion of medical men to the civil population. Another is that, whereas a soldier may be made by six months' training, the average time required to prepare a

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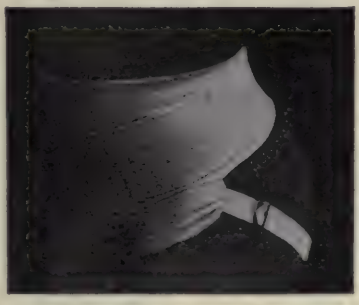

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physician for practice may conveniently be estimated as from five to seven years, according to whether or not we include the two preparatory years of college study. The third reason, partly bound up with the second, is that most physicians have not reached their greatest possibility for usefulness until they approach middle life.—*Colorado Medicine.*

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### Dirt

The *Saturday Review* of April 27th contains the following: Dirt we know is democratic; but now we are told on authority that it is patriotic. Dirty houses, dirty windows and carpets, dirty clothes, are badges of patriotism as honorable as any medal or ribbon. Alas, there is little need to exhort the community not to wash its clothes, for laundry charges are prohibitive to all but the war-wealthy, and bleacher's "blue," largely imported from Germany in peace, is growing scarcer. We hope that it will not occur to Lord Rhondda to ration soap, as it will first be trebled in price, and then disappear under his fell protection, like rabbits and salmon. Does it never occur to these smutty patriots that dirt is dangerous, and a sure breeder of diseases? The recent outbreak of smallpox is undoubtedly due to the enforced neglect of cleanliness.—*Medical Press.*

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### Retinal Detachments

In *The Royal London Ophthalmic Hospital Reports,* Part II, Foster Moore has added thirteen cases of retinal detachment, in renal retinitis, to those already published. He considers that they are dependent solely on the retinitis, which is generally of a severe type, and that they are independent of œdema of the rest of the body. He says that tephritis does not cause detachment in the absence of retinitis, and that the liability to detachment is largely proportional to the severity of the retinal changes; but he is of opinion that the immediate cause of a detachment is an active subretinal exudation.

Although the prognosis as to life is not modified by the existence of a retinal detachment, to be blind is a sad handicap, and any light that can be thrown upon such an obscure affection ought to be welcomed. If it is a subretinal exudation that causes the retinal detachment, we ought to try to ascertain the cause of the exudation. That cause may have been at work

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long before there is any nephritis, and it is probable that neurotic anasarca, which is met with long before the kidneys are affected with what is called nephritis, and long before any œdema is present, may have some causal relation to detachment of the retina. The anasarca is very marked in the eyelids, and it may be on the retina also.—*Medical Press.*

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### Treatment of Gonorrhoea in Antiquity

Alex. Renaud in a recent Paris thesis gives some details of the ideas which prevailed as to the nature of gonorrhœa in the early days of medicine. Hippocrates, in the fifth century before Christ, believed that purulent discharge from the urethra depended on carnosities in the canal; Galen, in the second century of the Christian era, held that it was an involuntary emission of semen—hence the name "gonorrhœa," by which he called it. This was also the teaching of Coelius Aurelianus in the sixth century, and of Bernard Gordon in the thirteenth. In the ninth century the Arab physician Rhazes recommended an antiphlogistic therapy, together with injections of honey water, with decoction of quince seeds. To cicatrize the canal he injected white lead or antimony. Gordon advised bleeding, emesis, and red cerate. For retention he prescribed water baths, combined with the application of living or crushed bugs to the penis. In this he may have imitated the practice of Avicenna, who, to excite the flow of urine, introduced a louse into the patient's urethra. In the eleventh century, Constantine, the African, recommended injections of woman's milk. In the fifteenth century Marcellus Cunanus used cow's, goat's, or woman's milk in the same way, with purging, diet and oil inunctions as adjuvants. As a preventive measure the school of Salerno recommended micturition immediately after coitus. In the thirteenth century, William of Salicet advised washing out with water after suspicious intercourse, and his pupil, Lanfranc, used ablutions with equal parts of water and vinegar, to which the patient's urine was sometimes added. John of Gaddesden is credited with the invention of the suspensory bandage; at the end of the fourteenth century, the same device was used by Guy de Chauliac. For the treatment of the discharge he used injections of oil of scorpions or pigeon's droppings diluted in lye, and strained. Like Avicenna and Gordon, he believed in the efficacy of lice and bugs applied to the meatus.—*The British Medical Journal.*

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### A Bacteriological Study of Cigars

Randle C. Rosenberger has made a bacteriological study of 118 cigars, taken from twenty-eight different stores, where they had been, in many cases, exposed to the air and dust of the store, and from the pockets of individuals. Most of the cigars were of popular brands, which sell at 5 or 10 cents each. Cultures were made from the mouth end of the cigar as soon as possible after purchase, and in some cases tobacco was taken from the centre of the cigar and placed in the sterile bouillon. Without exception, abundant bacterial growth was demonstrated within twenty-four hours. Spreads were made from the cultures and were stained with methylene blue and by Gram's method. In the majority of instances spore forming organisms developed, among them being *B. mycoides, B. simplex, B. cohærens, B. subtilis, B. megartherium, B. albolactus, B. mesenterious fuscus.* Streptococci were found in four instances, but were not obtained in pure culture. *Staphylococci albus* and *aureus* were isolated in pure culture in fourteen instances, but guinea-pig inoculation produced no lasting effects. A small motile organism resembling *B. coli* in morphology was found in cultures from twenty-five cigars, but only two gave indol production and fermented various sugars. Cocci resembling the gonococcus were obtained from a cigar taken from the pocket of an individual. The bacterial flora were just as abundant in the case of cigars wrapped in paper or in tinfoil; and in cultures made from the inside of the cigar, the spore-bearing organisms were more abundant than non-sporiferous bacteria. Rosenberger points out that, though no virulent pathogenic or pyogenic organisms were demonstrated, the occurrence of staphylococci makes it evident that the practice of moistening the end of cigars with the mouth or tongue, or twisting the end with the moistened fingers, should be forbidden—a practice which certainly exists in the small manufacturing plants; and that the selection of individuals for making cigars should be just as strict from the point of view of skin diseases, tuberculosis, etc., as in the case of waiters or dairymen. He also suggests that the end of the cigar should be clipped with a cutter and not bitten. —*Medical Record.*

# The Canadian Practitioner and Review

Vol. XLIII. TORONTO, JULY, 1918 No. 7

## Original Communications

### MEDICINE AND DEMOCRACY*

By John P. Morton, M.B., F.R.C.S., (Edin.), F.A.C.S., Hamilton, Ont.

Exigencies consequent upon combining five Medical Associations into one great congress and consideration for the scientific programme have led to the suggestion that the President's Address be distributed rather than read at the meeting. My purpose will be to discuss certain problems, actual and prospective, confronting our profession to-day, and, if possible, to suggest solutions therefor.

Permit me to express my deep gratitude to the Association for conferring the presidency upon me, for I know there are many others more gifted and more deserving of this honor. I have been singularly fortunate in having the advice of men experienced in the work of the Association and a support from our local profession, highly unselfish and praiseworthy.

The thirty-eighth annual meeting is both unique and unprecedented. We have united all the large medical associations of Canada into one great Canadian Congress, to be held in Hamilton during this war year. The desire for this unity and conservation of energy by all the Associations was early noticeable, and following an invitation by the Ontario Medical Association, a conference of representatives from the Canadian Medical Association, Ontario Medical Association, Canadian Public Health Association, Ontario Health Association, and the Association for the Prevention of Tuberculosis was held at the Academy of Medicine, Toronto, on October

*Presidential Address, Ontario Medical Association, Hamilton, May, 1918.

25th, 1917. The spirit of co-operation between the participating associations was very evident and, without difficulty, amicable arrangements were easily arrived at for the congress under the auspices of the executive of the Ontario Medical Association. The necessary conferences between such important bodies in anticipation of and in preparation for the meeting in May have been very helpful and augur well for the future organization of our profession, if any action, defensive or constructive, may be contemplated. My deepest concern is that this congress, which is a new departure, and for which I must consider myself partly responsible, will commend itself to the profession from the standpoint of its scientific programme and will engender the spirit of co-operation among the different associations. If these objects are attained, may I express the hope that this precedent may occasionally be followed.

The logic of holding this congress seems so apparent to some of us, that it is almost superfluous to answer some quite honest criticisms to which the proposal has been subjected. Some have said that no meeting at all should be held during such a strenuous war year, but I must conscientiously differ from this opinion for an essential part of war work is to meet and understand the vital questions at home, and our profession at this time, both from the standpoint of its own good and from that of the welfare of the public, is confronted with some strikingly important problems. The report of the Royal Commission on Medical Education has been tabled, and the future of regular medicine in Ontario requires the immediate attention of our Association in shaping and carrying through a resultant government measure. Further, it becomes necessary for us to decide how we can be of use from a purely lay point of view during war times, and this is quite apart from the splendid record of our profession in the work of the Canadian Army Medical Corps. Again, it becomes necessary to consider the pending problems involved in the gradually changing relations between the Medical profession and the State, for these may result, in the not distant future, in the enactment of a Health Insurance Bill. These are sufficient reasons for the congress, but if any further justification were necessary, it might be found in the fact that we have committed ourselves to a scheme for the reorganization of our profession in Ontario on the basis of the county societies, and it

is fundamental to the success of this plan, not only that a meeting be held, but that a large representation be induced to attend from rural districts. We have been told that separate association meetings would be more stimulating and would benefit the several sections in which they were convened, but surely the great need for conservation of time and energy is a satisfying answer to this criticism.

Permit me, with pride, in the early part of this address, to indicate the increasingly onerous part taken by the medical profession in the great world war. The Ontario profession has been greatly honored and grandly represented by about 20 per cent. of its members who have joined the Canadian Army Medical Corps, and we are very proud of those who, at great personal sacrifice to themselves, have crossed the ocean to accept whatever appointment might fall to their lot, and in many cases to risk their lives for their country. Above all, will we enshrine in memory our heroes who have given their lives at the call of duty for the defence of country and liberty, and as Sir Berkeley Moynihan has so well said: "Let us write the epitaph they would most desire—'they have played the game,'" than which there is no higher meed of praise. The awful necessities of this terrible struggle exhibit human nature at its best, and, unfortunately at its worst, for our Old World has never witnessed a sadder paradox than this, that the greatest scientific geniuses are seen planning human destruction and then passing on the wrecks they have made for reconstruction to geniuses just as great. Happily for our profession, this work of reconstruction largely falls to our lot, and our only desire is that it shall be well and faithfully performed.

If this meeting of the Ontario Medical Association typifies any special idea, it is reorganization. For long, the progressives among us have recognized that unity has been sorely needed between the many medical clubs, societies and associations of Ontario. Uniformity of purpose and desire have undoubtedly been in evidence, but an absolute lack of organization for the attainment of these objects has been still more in evidence. At the Toronto Association meeting not more than an odd hundred would register from the remainder of the province. When the weight of a united profession was required to exercise its justificable influence on the authorities concerned with framing a medical bill which would decide the standing of our profession for years to come and define the

protection that the public might legally expect from exploitation by charlatans, those interested found the necessary initiative woefully absent and could discover no means whereby the medical voice of the province, though unanimous, could assert itself. Our own Association which should have, and did finally move in this matter, represented only four or five hundred of the three thousand practitioners. In marked contrast to our criminal want of organization, the irregulars, in their presentation of evidence before the Commission, fought as one man and employed the most effective legal talent. Our negligence, where the medical welfare of the public is so vitally concerned, is unjustifiable and for years much medical charlatanism has been made possible, because years ago, when this question was originally dealt with by our Legislature, the same spirit of professional lethargy was abroad. These facts and many others have spelled lack of efficiency and have rendered absolutely necessary a radical change in organization. A carefully selected committee has drawn up a new constitution and by-laws; these were adopted by our Association at a representative meeting on October 25th last, and our gathering this year is notable as being the first held under the new regulations. We confidently expect by these regulations, to be enabled, in a more comprehensive and effective manner, to serve the public and the State. In this departure our committee has wisely accepted the successful precedent of the American Medical Association. The guiding principle of the new constitution is to render the province a unit by adequate organization, and this is well accomplished by giving the county societies proportional representation on a Committee of General Purposes which will be the governing body of the Ontario Association. The ethical standards also rest with the local bodies, for only their members in good standing may join our Association. Democracy is thus applied to the organization of the medical profession, for the parent provincial association now really voices the medical opinion of the province, as our registration contains theoretically every doctor in the province. To render this representation vital and actual, each local society must be active and speak authoritatively for its own district. To bring about this desirable state I would suggest that we again follow the example of the American Medical Association and appoint councillors, who, in groups of possibly three, might be placed as advisors for and supervisors over the

societies in certain territories, helping to arrange meetings and to make available good material for programmes. Moreover, they would assist in establishing societies in unorganized parts and would be required to report to the Association for their respective districts. To the extent that local societies are not representative and that localities are unorganized, or, if unorganized, are inactive, to this extent does our Association under its new constitution, fall short of its ideal. I am speaking to the question for Ontario, yet it is devoutly to be desired that this plan for reconstruction be applied to the whole Dominion. Contemplate for a moment the splendid position of our Canadian profession realizable by the consummation of this scheme. Every district would have an active local society, and these bodies, through proportional representation, would control their respective provincial associations which they would unite to form. These provincial associations, in their turn, would unite to constitute and control the Canadian Medical Association. This complete system, already partly in operation, would reflect the democratic spirit of the times and would function defensively and constructively for the highest good of the profession and the public. We would secure much greater concentration of influence, more unity and definiteness of purpose, better uniformity in our ethical and educational standards, a marked improvement in co-operation between our local societies and associations, and increased attendance at our meetings. Our Association is deeply indebted to those of our members who have not only dreamed of this new order of things, but have been instrumental in its realization.

The Royal Commission on Medical Education, after numerous sessions, at which every opportunity for giving evidence was afforded, has printed its findings, and, although we purpose to argue in committee many points which seem unsatisfactory, we have, on the whole, reason to be pleased with the report. The commission recommend that the care of the sick be in the hands of the medical profession, and that any one to whom the province gives this important privilege, must have at his disposal the available knowledge on all subjects pertaining thereto. Certainly the only manner in which we can effectively answer and counter the claims of the irregulars is to incorporate in our own teaching system all the therapeutic measures which have proven themselves beneficial. The report insists that we have been somewhat prejudiced and that physico-therapeutics must form a more prominent part of our

teaching, and that an adequate staff and apparatus be provided for this purpose. Someone has said that "Convictions are more dangerous to truth than lies," and we have probably been too sure that our system has covered the whole field of treatment. The history of the wonderful changes in therapeutics from Hippocrates to these times persuades us to keep our minds open for suggestions from whatever source. William Harvey's first publication, "Motions of Heart and Blood," was unable to pass medical censorship for twenty years after it was written. Renouard says that medical men of his day considered Harvey demented and that he lost most of his practice, in spite of the clearness and method with which he developed his ideas. Lord Lister's fight, extending over years, for the recognition of the principles of antisepsis, is still more impressive. Without contradiction one may say that prejudice, doubt, and active opposition have been the outstanding characteristics of the fate of really valuable new medical truths. Next to the antagonism of the Church, probably our own prejudices and conservatism have been the worst barriers to progress. The Royal Commission was right in this criticism, and it behooves us for our own welfare and the welfare of those in our charge, to keep minds open for the consideration of even apparently heterodox treatment. Our teaching bodies should be especially alert, and might include a progressive medical committee for the testing of even accidentally suggested therapeutical methods. Next winter a bill, based on this report of the Royal Commission, will come before the Legislature, and because our cause is just and we are in a position properly to present it, we are hopeful that the measure in its final form will do our profession full justice. Certainly it would be unworthy of us to gain control over the health of the community by organization, lobbying or other political device, unless we conscientiously strive to maintain the highest possible standard of efficiency.

I feel called upon in this address to introduce certain other considerations which seem to me of vital importance for the welfare of our profession and of the public whom we serve. "Service" is the best and most significant word in the English language to-day. Consideration for others is certainly the avowed ideal of sane modern democracy. The stupendous world conflict, in which at this moment great armies are advancing and recoiling, with the result wavering in the balance,

will decide whether the German point of view is to stand or fall, that might is right and that the weak have only the privilege of servitude. The application of this saving principle of service to our profession raises the question whether in simply caring for the sick we are fulfilling our whole duty to the public. From my viewpoint, our medical associations, societies, clubs, and round tables should not be for self-betterment alone but should actively engage in the great service of medically educating the laity. No government cares to enact laws without the support of public opinion, and it is equally desirable that we should secure effective lay co-operation by education before seeking general support for the many great public health movements. Our health officers may enact all manner of legislation, but, until the public wittingly co-operates, these will largely fail to obtain the desired prevention. If then our organized profession is to live the larger life of service, it must use its organizations for public education. But my appeal is also to the individual physician to expand his sphere of usefulness by using his wonderful opportunities to inculcate the accepted principles of prevention and cure of disease. Few of us now act on the old-fashioned notion that the doctor should, like the Asclepiadæ in the old mystical days of healing, surround himself with an atmosphere of mystery, which too often is but the cloak of ignorance. You will not interpret this to mean that the patient should be fully informed of his disease, but there is no reason why the physician should not be a medical missionary of education, and thus fulfil the modern democratic principle that we should think in terms of our neighbor. The greatest service then that our organized profession and the individual physician can render the public is to educate them medically to a reasonable extent. This would strengthen the hands of our public health officers, for enlightened public opinion in such problems as the venereal diseases and tuberculosis would help and force our legislators to keep pace with it; we ourselves would be stimulated to maintain higher standards both in teaching and in ethics, and further, the public generally would not so easily become the dupes of charlatans, who would then be rated at their true value.

Another consideration to which I would invite your attention may be put in the form of a question. Do we as a profession, in the great responsibility entrusted to us, adopt adequate means for safeguarding the public from incompetency

among ourselves? Do our recent graduates possess the very highest possible standard of theoretical education and the practical knowledge necessary to treat and operate for disease? In too many cases, I fear, they acquire at the expense of their private patients, their practical knowledge, which should have been gained in some hospital. This might be prevented by greater teaching efficiency and by improving the facilities for clinical and practical instruction. Full-time professors in at least medicine and surgery are essential. Again, after a man has been in practice for a number of years and makes no attempt to keep in touch with modern ideas, he becomes educationally mired and is a medical menace in his community. Unfortunately this type of doctor often learns ways of beguiling the public as fast as he unlearns his medicine. Can the public be protected from this danger? Some have suggested that we all undergo periodical examinations to be conducted by the whole-time men at the teaching centres. Even classification of practitioners, perhaps every seven years, has been mentioned as a help. A more practical expedient would be to require each one to undertake post-graduate work at specified times, and proper facilities for this would then be obligatory upon all university and hospital centres. Moreover, all teaching bodies might be able, through local societies, to provide courses of extension lectures.

This seems a suitable juncture to mention the very commendable propaganda on the part of the American College of Surgeons for standardization of hospitals on the basis of efficiency. Taking into consideration the various conditions under which hospitals operate, certain requirements would be laid down, and according to the degree to which these requirements are fulfilled, would the hospitals be classified. The factors named as imperatively essential are, the keeping of good case records and the utilization of these records as tests of efficiency; the maintenance of proper laboratory facilities; and the presence of a staff with good character. In the Bulletin issued in March of this year by the college, these three requirements of a minimum hospital standard are stated as follows:

Case Records. That the hospital keep in a systematic manner case records of its patients together with a convenient summary of each case; and that it utilize these records in analyses of its medical and surgical efficiency.

Clinical Laboratories. That as implied in the foregoing requirements concerning case records, the hospital provide

either directly or indirectly, the laboratory facilities, which in the science of medicine are essential in the diagnosis and treatment of patients admitted for care under normal conditions.

Division of Fees. That the hospital trustees or governing authorities in co-operation with the staff take action definitely to prohibit from all services of the hospital the practice of division of fees.

Although these considerations are accepted by the committee as a minimum for testing hospital efficiency, the various hospital staffs are requested to consider other features of the work, which, in their judgment should become part of the standardization programme. These are: The training of internes, the training of nurses, obstetrics, pædiatrics, cross infections, dietetics, anæsthesia, intelligible financial accounting, hospital administration, and pharmacy.

To safeguard the welfare of the public then, the highest standard of hospital efficiency is necessary, for the people now look upon this service no longer as a luxury but as an inherent right. The Regents of the American College believe that a proper accounting in hospital work is inevitable, and that if the initiative is not taken by the profession, it will, as has been done in some cases already, be taken by the public. The better to safeguard the public from inefficiency among ourselves, I would add the following requirement to the criteria of efficiency noted by the Regents, viz.: That all hospitals be properly equipped for post-graduate studies.

Among prospective problems may be placed the future relation of the medical profession to the State, which is claiming more and more attention in all countries. We are experiencing great democratic changes and are informed that still greater upheavals will occur after the war. Our profession may soon be required to formulate some plan whereby the poorer and more medically neglected sections of the population will have the right and privilege to ask for free medical or surgical care. The cost of this so-called health insurance system would be divided between the patient, the firm, and the government. Hospitals and other properly equipped diagnostic centres would be established, where all necessary examinations for arriving at correct diagnosis would be carried out. The greatest gain of this plan would be the abolition of charity work, the very name of which has a stigma attached to it. Gladstone has said that we must do away with all charity, for we are sorry when we dole it out and we are sorry when we withhold it.

Patients under this scheme would feel entitled to a physician, to a nurse and to the necessary medicaments. Of hardly less benefit would be the wonderful opportunities offered for scientific social work, for the presence of trained nurses in any of these homes would be a wonderful educational factor in cleanliness, and, let us hope, in godliness. Medical assistance would undoubtedly be called earlier with a consequent prevention of much disease and curtailment of many epidemics. There would be required some system of referees to assure efficiency and to prevent men lowering themselves to lodge practice methods by abuse of the system. The experience of all the other countries which have tried this plan of health insurance should enable us to evolve a very satisfactory Act. Whatever the future may hold for us in this regard, thanks to the reorganization of the profession, we are not likely to have a measure of this character enacted without thorough consideration by the medical men whom it most concerns. The medical profession can be proud of its record through many centuries, and it is to-day the only one which offers its services without cost to thousands in every city in the world. Now, although this is highly unselfish, and although we have been thoroughly conscientious in the performance of this work, it is justifiable to inquire, if, in the light of modern social service investigation, we are wise to continue this form of charity. Carried to the excess which is necessary in looking after the great dependent sections of our communities, it leads to a sense of superiority on the part of the donors and to a reprehensible pauperism of the recipients. Our social service scientists tell us that in so acting we are dealing with the evil from the wrong standpoint. Rather should we co-operate with the laity in initiating and furthering all movements which will tend to prevent disease. We are advised to be foremost in working for all child welfare organizations, for propaganda against venereal diseases and tuberculosis, for all public health work and other educative schemes. Our heartiest support should be tendered to all properly organized community centres and playgrounds, and in a word for all social service enterprises. These preventive organizations would make unnecessary a large part of our present charity work for the poor. If a good Health Insurance Act were in force, the poorer classes would be provided for medically without charity, and the self-sacrificing spirit, so proverbial of our profession, would be much more effectively exhibited in the ways above noted.

In bringing this address to a conclusion, permit me to express the same hope as did my immediate predecessor that before this Association again convenes, the awful world-convulsing war will be finished and that the principles of liberty and democracy will have triumphed. Just as in the individual, evil and good strive for the supremacy, so in the world as a whole, fearful conflicts seem necessary to assure that steady progress of ideas in which our faith for the future lies. In our private business and national life, heart-searching is required, for there is much of that very might-is-right spirit, typified by our foes, to defeat which we are pledging our property and our lives. It is gratifying to know that in the work of reconstruction which this war makes necessary, the medical profession must take a large and noble part, for whatever change there be in the spirit of the age, it cannot sound a more inspiring watchword than ours—SERVICE.

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**St. Andrew's College**

It was announced June 26th that the St. Andrews College Military Hospital would be much larger than was originally intended, perhaps the largest in Canada. In addition to the original site of twenty-three acres the Government will use the old lacrosse grounds with an area of about seven acres, and also a big stretch of property on the crest of the hill overlooking Rosedale. A number of pavilions of stucco will be erected similar to those at Whitby. It will be known as the "Rosedale Military Hospital."

## APPARENTLY DROWNED PERSONS

It seems fitting during the early summer to again describe the Schafer method, which is recommended by the Provincial and Toronto Boards of Health.

### Rule No. 1.

Lose no time in recovering the body from the water. Always try to restore life; for while ten minutes under the water is usually the limit, still persons have been resuscitated after being

Fig. 1.

under water for thirty or forty minutes. Do not lose time by taking the body to a place of shelter—Operate Immediately.

### Rule No. 2.

Quickly lay the person prone, face downwards (as seen in Fig. 1.), with stomach resting on a barrel or roll of clothing, so the head will be lower than the rest of the body and the water will run out from the throat and lungs. Wipe dry mouth and nostrils. Wrap the corner of a handkerchief about the fore-finger and clear the mouth of all mucus and slimy substance back as far as the top of the throat. Rip open the clothing

on chest and back, and keep the face exposed to the air. *Separate the jaws and keep them apart* with a cork, stone, or knot in a handkerchief.

### Rule No. 3.

Remove the roll of clothing from underneath the stomach of the patient. Kneel by the side of or astride the patient. Place your hands over the lower ribs. Lean forward and put your weight straight over the lowest ribs. Exert this pressure for three seconds. To count three seconds say "one thousand and one, one thousand and two, one thousand and three."

### Rule No. 4.

Do not remove the hands from the ribs; but release the pressure from the ribs for two seconds, by squatting backward,

Fig. 2.

as in Fig. 2. To count two seconds say "one thousand and one, one thousand and two."

### Rule No. 5.

Again exert pressure straight over the lowest ribs for three seconds, as described in Rule 3; then again release pressure for two seconds, as described in Rule 4. Alternate thus (three seconds pressure and two seconds release) about twelve times a minute, until breathing is restored. This method of resuscitation at once expels water and produces the identical results of normal breathing.

### Rule No. 6.

If another person is at hand to assist, let him do everything possible to keep the body warm, by sheltering it from the wind, rubbing hands and soles of feet, and making hot applications. Warm the head nearly as fast as the other parts of the body to avoid congestion. Camphor or ammonia may be applied to the nostrils to excite breathing.

### Rule No. 7.

Do not give up too soon. Any time within two hours you may be on the point of reviving the patient without there being

Fig. 3.

any sign of it. Send for a physician as soon as possible after the accident. Prevent friends from crowding around the patient and excluding the fresh air.

### After Treatment.

After breathing is restored, remove the patient to a warm bed where there is free circulation of fresh air. Administer in small doses stimulants (hot coffee, ginger tea, hot "sling") as soon as patient can swallow, being careful not to let the patient choke or strangle. There is great danger that the patient may contract congestion of the lungs.

## SOME REFLECTIONS ON THE CANADIAN MEDICAL WEEK IN HAMILTON

The word reflections is not intended to be used in connection with the recent gathering of the " medical clans " in Hamilton in an invidious or critical sense, but rather the reverse. There was much to praise and but little to criticize. In fact the meeting was big from all points of view. A galaxy of medical and surgical talent was represented in the papers read, and from the standpoint of attendance the high-water mark of any Canadian medical meeting was reached. The distinctive features of the week were the extremely high average of excellence of the papers presented, and especially the splendid quality of the papers contributed by the physicians and surgeons of the United States. Indeed, it may be said, without detracting in any way from the merit of the papers given by Canadian medical men, that both in quantity and quality these were quite overshadowed by those presented by their confrères from across the line. If criticism can be directed against the management of the meeting it must lie in the fact that there was somewhat of an embarrassment of riches. There was such a superabundance, almost a plethora of good things, that one was apt to become rather confused. It was a feast of reason of so great diversity and extent, that it was difficult to select the *bonnes bouchee*, and that one was likely to miss a particularly instructive or original paper. However, it is obvious that this was a fault on the right side.

The description of the meeting that follows does not pretend to be an accurate and exhaustive account of the proceedings; this would be impossible in the space allowed by the editor, but is more or less a discursive description, in which an endeavor will be made to present the most salient points.

As is well known the congress at Hamilton was a joint meeting of the Canadian Medical Association, the Ontario Medical Association, the Canadian Public Health Association, the Ontario Health Officers' Association, and the Canadian Association for the Prevention of Tuberculosis.

All the sessions were held in the Royal Connaught Hotel in Hamilton, with the exception of the sessions of the medical section of the Canadian Medical Association, which took place in Loew's Theatre, situated exactly opposite to the Connaught Hotel.

The first meeting of the week was that of the combined sessions of the Ontario Health Officers' Association in conjunction with the Canadian Public Health Association, including the recently organized Child Welfare Section. The opening ceremony took place on the morning of May 27, in the Assembly Hall of the Connaught Hotel, and was performed by the Duke of Devonshire, the Governor-General of Canada.

The first paper read was by Lieut.-Col. John W. S. McCullough, chief health officer for Ontario and secretary of the Ontario Health Officers' Association. Col. McCullough's paper dealt mainly with the venereal problem and the efforts of the Ontario Legislature to control the disease.

Capt. W. H. Hattie, of Halifax, N.S., gave the address as president of the Canadian Public Health Association, and this was followed by the address of Capt. H. W. Hill, of London, Ont., as president of the Ontario Health Officers' Association. Capt. Hill especially laid stress on the point that there were three essential fields for public health work—venereal disease, tuberculosis and child welfare. In his opinion the other infectious diseases were of small consequence. As for the venereal problem, Hill thought that the solution rested in the suppression or adequate control of illicit intercourse. The women of the streets could be dealt with, but the case of the woman who worked and gave herself to illicit intercourse was most difficult to grapple with successfully. A noteworthy point and one that is often overlooked brought out by Hill was that a negative Wassermann test is no proof that infection is not present in the primary stage of syphilis.

Another extremely important point which was freely discussed after the reading of the papers was as to the question of disinfection when convalescing from infectious disease. Hill insisted that disinfection by formaldehyde and permanganate of potassium after scarlet fever is of no avail, and stated that with regard to scarlet fever so long as he detected any discharge from the ear, or if there was a herpes, he considered infection still transmissible, and refused discharge. A commission was appointed in Ontario to investigate into and report on the employment of quarantine and terminal disinfection.

The child welfare session, held on May 28, was productive of some good papers and interesting discussions.

The eighteenth annual meeting of the Canadian Association for the Prevention of Tuberculosis was held on May 29. Addresses of welcome were given by the Mayor of Hamilton,

Chas. G. Booker; the president of the Ontario Medical Association, Dr. J. P. Morton, and others.

Capt. Geo. D. Porter, of Toronto, secretary of the Executive Council, read his report, in the course of which he stated that records of those rejected on account of tuberculosis could be obtained from the army, and these cases followed up in an educational way, as in the United States. He also pleaded that food production should be increased, in order to keep up the vitality of the population, and so lessening the danger of infection by and spread of tuberculosis.

Capt. H. W. Hill, of London, Ont., made some very telling points in a paper read by him. He stated that open cases in children were very rare, and urged that open cases should not be allowed to commingle with closed cases, and moreover stated that in his opinion open cases should not be allowed to mix with open cases. He drew attention to the point that it was essential to differentiate between the human and bovine forms of tuberculosis, and that pasteurization would end bovine tuberculosis. Hill said that he did not believe in the widely held theory that tuberculosis was almost always contracted in childhood. He held the view that a very large number of cases were contracted after the age of sixteen.

It had been arranged in the scheme of the meeting as first conceived by the originators to hold a special symposium dealing with the medical and surgical diseases and disabilities of soldiers and the treatment thereof. However, it was pointed out by Surgeon-General Fotheringham that such a plan was too ambitious by far, and it was decided to prepare a much more modest programme and to limit the symposium to the reading of five papers, and to devote to their reading and discussion a part of one evening. The papers read were good, that on " Psychogenetic Conditions in Soldiers, their Etiology and Treatment," by Lt.-Col. Colin Russell, C.A.M.C., being of special interest.

The thirty-eighth annual meeting of the Ontario Medical Association in conjunction with the Canadian Medical Association was held on May 30 and 31.

It was said in the preamble to this account that the papers contributed by physicians and surgeons from the United States surpassed in quality and value those given by Canadians. This statement applies to the meeting of the Ontario and Canadian Medical Associations and not to the meetings already commented on, where local talent, if such a term is applicable to

the medical profession of a land the size of Canada, reigned supreme.

Among the many splendid papers read in the medical section of the combined sessions of the Ontario and Canadian Medical Associations, one paper stood out, because it dealt with an almost new epidemic and virulent disease, and because it described all that is known of the disease from all aspects in the most exhaustive manner.

The paper referred to discussed the pneumonia of army camps and was contributed by Dr. W. G. MacCallum of Johns Hopkins, Baltimore. It was shown in the paper that the study of pneumonia in an army camp in the United States revealed numerous cases of lobar pneumonia due to one or other types of streptococcus. The new type of pneumonia, however, is a broncho-pneumonia due to infection with a hæmolytic streptococcus. It frequently follows measles and also scarlet fever. MacCallum has given to the hæmolytic streptococcal broncho-pneumonia the appellation interstitial broncho-pneumonia on account of the rapid infiltration of the tissues. This form of pneumonia is of a very virulent type and in MacCallum's opinion is transmitted by direct contact, by means of mouth spray and so on. No effective method of treatment has been found out. MacCallum thinks that in vaccine therapy will be discovered the means of successful treatment or of prevention by immunization.

In the surgical section Dr. Jasper Halpenny, of Winnipeg, read a well thought out paper on " The Training of the Surgeon," in which he somewhat severely criticized many of the methods now in vogue in this direction.

Dr. E. J. McGuire, of Buffalo, read a paper on "The Surgery of Colon," in which he argued that the verdict of surgeons on Lane's theory of and work on intestinal stasis was, to a great extent adverse. He claimed that ileo-sigmoidostomy should be discarded, as an operation of election, resection being the ideal procedure.

The address in Obstetrics was delivered by Dr. Joseph De Lee, of Chicago, who dealt with methods and operations for reducing fœtal mortality with special reference to the newer methods of Cæsarean Section. Dr. Isaac Alt, of Chicago, gave the address in Pædiatrics, taking as his text asthma in infancy and childhood. Dr. Lewellys R. Barker, of Johns Hopkins, Baltimore, gave the address in Medicine, discussing the significance of heart murmurs found in examination of candidates

for military service. It was pointed out in this address that there were heart murmurs which did not incapacitate a man for military service. Some of these murmurs indeed were made by the organs in the region of the heart, while there were murmurs which meant nothing; the man who had them was just as fit to carry on as if the murmur was not apparent. Dr. Barker's address emphatically demonstrated the point which has been long obvious, that in the examination of recruits for service, the examiner should be especially skilled in heart examination. On the afternoon of May 31, a symposium on intra-cranial pressure was held. Dr. J. J. R. Macleod, of Cleveland, Ohio, discussed the physiology of this form of pressure. Dr. W. R. Hamilton, of Montreal, dealt with it from the medical and Dr. A. E. Garrow, of Montreal, from the surgical sides, respectively. The address in Surgery was given on the evening of May 31, by Dr. Chas. H. Mayo, of Rochester, Minn. He pointed out that cancer was greatly on the increase in the United States, and, referring to treatment, said that radium was of considerable value.

In the sections in ophthalmology and laryngology, otology and rhinology, many exceptionally good papers were read, but as this account is no more than a bird's eye view of the meeting, it is not possible to refer to them in detail.

On June 1 the conference ended with a combined medical and surgical clinic, under the auspices of the Hamilton Medical Society and held in the Mount Hamilton Hospital. Dr. Chas. Mayo dealt with the surgical aspects of the cases presented, and Dr. Frank Billings, of Chicago, should have discussed these same cases from their medical points of view. Dr. Billings, however, was unable to be present, his services at Washington were so indispensable that the Surgeon-General of the United States Army was unable to spare him.

Of the papers read in the section in laryngology, otology and rhinology, one was of particular interest for the reason that it was presented by a native of Hamilton, and also because the subject matter of the paper was of much value. The paper in question was read by Dr. Gordon B. New, of Rochester, Minn., formerly of Hamilton, and dealt with the value of radium as observed during the past three years at the Mayo Clinic in the treatment of lesions of the eye, ear, nose and throat. This paper was, in fact, a report on the value of radium as observed during the past three years at the Mayo Clinic in the treatment of malignancies of the nose, sinuses, pharynx, larynx and mouth.

The report, although guarded in its conclusions and discriminative, was highly favorable to radium as a therapeutic agency in lesions of the eye, ear, nose and throat.

While the meeting was confined almost wholly to business, the comfort and pleasure of the guests, and especially of the lady visitors, was not forgotten. Several excursions were provided, and a visit to the Mount Hamilton Sanatorium was arranged. On four evenings of the week informal dinners were held in the assembly hall of the hotel, after which addresses were given and entertainments of a musical nature provided. At the Friday evening meeting an informal smoking concert followed the addresses. The patriotic enthusiasm of those present was aroused to the highest pitch by a fervid and eloquent speech made by Major Laughlin Watts, of the Black Watch, a poet, an orator, and a chaplain in the British Army. He spoke with true Celtic poetic fervor, and held the tense attention of the audience who listened to the burning words as almost coming from one inspired.

The scientific exhibits were deserving of notice, and perhaps especially those from the Canadian Army Medical Corps Museum. The clinical laboratory section also attracted a good deal of notice. A part of the section was under the charge of Capt. A. H. Caulfeild, who has been recalled from France for the purpose of demonstrating the treatment of gas gangrene, and to make further researches as to causation of that condition.

There were moving picture and X-ray sections.

The meeting was a conspicuous success, and reflected great credit upon those responsible for its organization. The foregoing account gives but a very inadequate conception of its size and importance. However, as stated at the commencement it is no more than a discursive description of some of its outstanding features and might be more aptly termed impressions than reflections. The attendance was in the neighborhood of one thousand.

C. A. C.

# Editorials

## HONORABLE DOCTOR PYNE

Dr. R. A. Pyne has retired from politics, and is engaged in important work in the Civil Service. He is a comparatively young man (being in his 63rd year), and we have every reason to hope and believe that he will be spared in health and comfort for many years to come. He was ever a public spirited man in a broad sense of the word. He graduated M.B. and M.D. from Toronto University in 1878-80; he received the honorary degree of LL.D. from Toronto in 1905, and from Queen's in 1910. In his boyhood days he was a volunteer, and was appointed Assistant Surgeon 10th Royals in 1880. He was appointed Registrar of the Ontario Medical Council in 1880 and continued in that position until 1907. As Registrar he proved useful not only as a secretary but also as a confidential adviser to the various executive councils for many years. He also took great interest in educational and health matters. He was a member of the first Board of Health in Toronto; for a time member of the High School Board; Chairman of the Toronto School Board; and also a member and chairman for some time of the Toronto Free Library. During many of these years he was active in politics, and was a member of the Provincial Parliament for twenty years, being first elected for East Toronto in 1898, and last for North-East Toronto in 1913. He became Minister of Education in Sir James Whitney's Government in 1905,

and remained in that position until the time of his resignation last May. As a Member of Parliament he was generally popular on both sides of the House; and was a favorite with the members of the Government, and especially with two Premiers, Whitney and Hearst.

Dr. Pyne has a host of friends among the physicians of Ontario, all of whom wish him well. Although we have no idea that he will ever again practice medicine, we hope that he will not for a long time say good-bye to the members of that profession.

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## R.A.M.C.

We are very glad to know that the work of the British Army Medical Service is very highly appreciated by all classes both in Great Britain and the Colonies. The London *Times* in a recent article spoke in the most glowing terms of the work which had been accomplished by Sir Alfred Keough (who recently resigned from the position of Director-General of the A.M.C.), and those associated with him. As announced in our last issue General Goodman has been appointed in his place, and it seems certain that the Service will lose none of its efficiency on account of this change. In the article referred to special mention is made of the wonderful work done in regard to typhoid fever, and the *Times* admits that the work of this Army Medical Corps has made the health of the troops at home better than that of the civilian population, and also that the health of the troops in action in France is better

than the average health of the army in peace times. We have to confess that many of the favorable results referred to far exceeded the expectations of the most optimistic of our physicians.

## THE GERMAN LANGUAGE

It is not remarkable that there should be some discussion regarding the teaching of German in Great Britain, and also in Greater Britain. We regret to find that in certain discussions personalities have been indulged in, and some individuals have been rather bitterly attacked. For instance, the Rev. Mr. Millarr, pastor of Bond Street Congregational Church, devoted a considerable portion of an address in criticizing President Falconer of Toronto University. He said, "if he is a real student of history he understands how the German armies have attacked France again and again, and have carried death and destruction to other nations of Europe. Probably President Falconer does not know that in 1912, when the Kaiser was arranging for this campaign, he decided that after the victory Canada should be exploited by a syndicate of Germans. In that, if they had been successful, President Falconer would not now be occupying his present proud position—a German would be in his place." These words are not in themselves of great importance. They represent, however, the feelings of a large proportion of the Canadian people. It happens unfortunately that in the discussions that have been taking place in recent years as to the comparative methods of British and German systems of teaching

respectively, the University of Toronto took the German side to such an extent that it was the most thoroughly Germanized teaching institution in North America when the war broke out. President Falconer himself was so thoroughly permeated with German ideas and German doctrines that he held British methods in considerable contempt, or so it appeared to a large proportion of the graduates. Notwithstanding the fact that he is in many ways broad, and is generally recognized as a very fine character, he became very one-sided in his views as to teaching methods. We are glad to state, however, that Sir Robert Falconer is very popular, and highly respected by a large proportion of our citizens. We have no doubt as to his loyalty. He is a good Canadian and a good Briton, and we feel certain that the logic of present events will soon broaden the narrow streaks which some think have crept into his character.

## THE MEDICAL WEEK IN HAMILTON

As we have frequently said in the past it was for long supposed that Montreal was the banner city of Canada because of its generosity to guests at all medical meetings. A few years ago Winnipeg jumped up to second place, while Toronto was rather a poor third, which did fairly well so far as Ontario Medical meetings were concerned. Suddenly Hamilton had something to say, and invited the Ontario Medical Association to hold a meeting there. That invitation was gladly accepted and the meeting was held in 1908. No one ever forgot the success of that

meeting which was so wonderful that many thought Hamilton could never repeat it. Toronto made a big effort in 1916, and as a result the largest and best meeting with an attendance of 450 was held under the Presidency of Dr. H. B. Anderson. Again Hamilton came to the fore, and in 1917 invited the Association to meet in that city this year. An invitation was also extended to the Canadian Health Association, Canadian Tuberculosis Association, and the Ontario Health Officers' Association. Finally an invitation was extended to the Canadian Medical Association, which was promptly accepted. Then the profession of Hamilton set to work, and secured the assistance of adjoining districts, and then of more remote districts. Their aim was to have a large Medical Congress which would be bigger and better than any Canadian medical meeting which had ever been held before. We are pleased to say they succeeded, and we have no hesitation in saying that all who were present are prepared to assert that it was in every way the most successful medical meeting that Canada has ever known.

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## DOCTORS AND THE LAW

So far as we know physicians are endeavoring to comply with both the law and the spirit of the various clauses of The Ontario Temperance Act. We noticed in a Toronto paper of June 11th some flaming headlines—"Whiskey, Doctors are Under Fire," "Many Physicians Building Up Busy Little Business, says Ayearst." Who is Ayearst?

It happens unfortunately that a few members of the profession committed flagrant breaches of the Act. In referring to a certain physician of Toronto, Mr. J. D. Flavelle is reported to have said that the great majority of the physicians were particular in issuing certificates for the purchase of liquor, and it was to the benefit and advantage of the medical profession to have all cases of abused privilege thoroughly investigated.

We are told that Mr. Flavelle is absolutely correct, and we are glad to know that he quite appreciates the efforts of the great majority of the profession to do what is right in the matter of issuing these certificates. We are also happy to say that we have reason to believe that the Vice-Chairman, Mr. Dingman, holds views similar to those of the Chairman.

There appears to be no doubt that some of the doctors have broken the law, and we hope that all such will be tried and punished. We may also add that the doctor who issues certificates by wholesale is not only breaking the law of the country, but that he is also, from a professional standpoint, acting in a disgraceful and dishonorable manner.

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## THE PRESIDENT'S ADDRESS

We are glad to publish in this issue the admirable address of the President of the Ontario Medical Association, Dr. Morton. We are very pleased to know that there has been considerable favorable comment on this address which is evidently very highly appreciated in all parts of the Dominion.

We have no desire to make any extended comments, which are really unnecessary because the paper is singularly clear and concise. He who commences to read it is pretty certain not to throw it aside until he has read the whole thing through. We desire, however, to call attention to Dr. Morton's remarks on Health Insurance. This subject is of vast importance, and is so considered in all parts of the world, and important laws in connection therewith have been enacted in various countries.

The Canadian Medical Health Association has paid great attention to it, and a goodly portion of the time of its meeting in Ottawa in 1917 was taken up by a very interesting discussion on the subject. Many of our Health Officers such as Drs. McCullough, Hastings, Hutchison and others are also studying the subject carefully.

Dr. Morton in his address strongly advised the establishment of some form of health insurance, and expresses the opinion that the cost under such a system especially in regard to employees should be divided between the patient, the employer and the government. He thinks that by such a plan there might be an abolition of charity work, the very name of which has a stigma attached to it. He told us that Gladstone had said that we ought to do away with all charity for we were sorry when we doled it out, and we are sorry when we withhold it.

# News Items

### The Case of Dr. Bott

The importance of re-education and vocational work among returned soldiers is now thoroughly recognized. It is generally conceded that no one in Canada has done better work of this sort than Dr. E. A. Bott, who has been working continuously in that department for more than a year in Hart House, Toronto. For some time it was feared that he would not be exempted from conscription, and a decision to that effect was given in one of the courts. President Falconer wrote a letter expressing much surprise at the attitude of the court, and pointed out that the work performed by Dr. Bott is of great national importance. Col. R. S. Wilson and others agreed with the President, and we are glad to say that Judge Ferguson granted an exemption as long as Dr. Bott is engaged at his present work.

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### The American Radium Society

The third annual session of this flourishing young organization was held at the Palmer House, Chicago, on June 10th. The following was the programme:—President's Address, John M. Lee, M.D., Rochester, N.Y.; "The Action of Radium Rays on Tissue," James Ewing, M.D., New York City; Discussion, Henry Schmitz, M.D., Chicago; "Study of the Efficient Radium Rays in Disease," Robert Abbe, M.D., New York City; Discussion, Frank E. Simpson, M.D., Chicago; "Radium in Gynæcology," Thos. J. Watkins, M.D., Chicago; Discussion, Leda J. Stacey, M.D., Mayo Clinic; "Radium—An Aid to General Surgery," Joseph B. Bissell, M.D., New York; Discussion, W. H. B. Aikins, M.D., Toronto, Canada; "Radium in Military Hospitals—A Report," William H. Cameron, M.D., Pittsburg.

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The Canadian Universities' Alumni Association, of Chicago, held a luncheon at the Sherman House on the 12th of June, at the time of the Meeting of the American Medical Association. The following graduates were present and greatly enjoyed the reunion. C. F. Neu, Indianapolis (Western, '94); Wm. H.

Marshall, Capt. M.R.C., Camp Grant (Trin. and Tor., '01); J. F. McConnell, Colorado Springs (Tor., '95); W. H. B. Aikins, Toronto (Tor., '81); D. E. McGillivray, Port Angelue (Trin., '99); Hugh A. Stevenson and W. J. Stevenson, London (Tor., '96); Chas. MacLachlan, New Rockford, N.D. (Tor., '89); John R. Hopkins, Denver, Col. (Tor., '93); M. W. Pascoe, Taft, Cal. (Trin., '98). Chicago was represented by Hugh N. MacKechnie (Tor., '01), John Milton Moore (McG., '88), W. L. Copeland (McG., '72), Chas. H. Long (McG., '88), Leonard St. John (McG., '72), J. K. McQuarrie (Tor., '95), Hugh A. Cuthbertson (Tor., '94), J. Fennell McKee (Tor., '94), James T. Campbell (Tor., '89), C. D. Hauch (Tor., '09), Norman Kerr (McG., '89), J. Arch. Brown, Kankakee, Ill. (McG., '93), D. A. Myers, Lawton, Okla. (McG., '98), John Segsworth, Wilmette (Tor., '94).

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It will be remembered that the veteran editor, Colonel Watterson, of Louisville, Ky., won the Pulser prize for what was decided to be the best editorial written, and published in the United States last year. The prize editorial concluded with the words "to hell with the Hapzburg and the Hohenzollern." This meets with the approval of some, but others think it is scarcely fair to hell, because the inhabitants of that district probably do not approve of such things as the murder of Nurse Cavell, Capt. Fryatt, and a lot of helpless babes.

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A new summer home for the Church Workers' Association of Toronto was built at Beaverton on the shore of Lake Simcoe, and formally opened by Bishop Sweeney, June 15th. Poor children and their mothers will be taken to this new home and kept there for periods of two weeks during the summer. The building will accommodate 100 children at a time.

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It has finally been decided to use St. Andrew's College as a military hospital. This is a considerable sacrifice for St. Andrew's College, which is certainly one of the best schools for boys in Canada. Fortunately, the authorities will be allowed to use a portion of Knox College for the next session, and possibly for two sessions.

There was an outbreak of anthrax in the County of Peel in the second week of June. A farmer named Snyder died from it June 14th. At the time of writing (June 17th) two others are supposed to have the disease, but are being treated by inoculations with a serum. It is feared that some others are also showing some symptoms of the disease. The provincial and local health officers are actively engaged in fighting the disease.

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It is stated that there are now about 200 soldiers in the wards of the Toronto General Hospital specially set apart for them. They are cared for by a staff composed of Col. Primrose, Capts. Geo. Wilson and Gaby, and a number of interne surgeons.

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The women of England are doing admirable work in the munition factories. Mr. Churchill stated in the British House of Commons that by their labor nine-tenths of the shells are made.

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# Obituary

## JNO. W. ANDERSON, M.D.

Profound regret was felt in the Maritime Provinces when the report came that Dr. Jno. Anderson, late house surgeon of the Victoria Hospital, Halifax, was dead, aged 28. We are told by those who knew him that he was one of the ablest and most promising young physicians in Nova Scotia.

# A Valuable Aid to Medical Skill

**"Wincarnis" promotes rapid recovery after Illness**

**Recommended by over 10,000 Doctors**

After professional skill has succeeded in carrying the Patient over the crisis of a severe illness a short course of "Wincarnis" promotes a speedy convalescence and a rapid return to Health. The constituents of "Wincarnis" are a Choice Wine, Liebeg's Extract of Meat, and Extract of Malt. These constituents are consistent with experiments which have proved that substances in alcoholic solution are more readily assimilated than substances in aqueous solution. Thus the constituents of "Wincarnis"—each possessing, in itself, certain dietetic and medicinal properties—are, in combination, intensified, thus producing in an agreeable form, a preparation of undoubted medicinal value, which is readily assimilable by even the most debilitated.

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in addition to possessing Tonic properties, acts as a restorative and aids starch-conversions. It is rapid in action, highly nutritious and more palatable than ordinary tonics. The use of "Wincarnis" is indicated in all cases of Convalescence from severe illnesses—especially after Influenza—in Anaemia, General Physical Weakness and in the Aged—in cases of Wasting or Inanition such as Phthisis and other tubercular affections. As a Nerve Food "Wincarnis" is most useful in cases of Neurasthenia and other Nervous Disorders.

The most scrupulous care is exercised to maintain the standardization of "Wincarnis," thus the dosage can be regulated precisely. And as "Wincarnis" contains no drugs, it can be prescribed with safety to even the weakest invalid. "Wincarnis" is warmly recommended by over 10,000 Doctors. "Wincarnis" is prepared by Coleman & Co., Ltd., Wincarnis Works, Norwich, England.

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# Personals

Dr. Futcher, who, for a time, had charge of the medical wards in Orpington Hospital, England, has returned to Baltimore.

Dr. H. H. Alger, of Stirling, Ont., who went overseas as M.O. of the 80th Battalion, with the rank of Lt.-Col., is now acting as Assistant Inspector of Drafts at Shorncliffe.

Dr. J. J. Fraser, Walkerton, who went to England as C.O. No. 2 Field Ambulance, with the rank of Captain, is now Lt.-Col. He has received the D.S.O., and was mentioned in despatches three times.

Sir James Grant is the only living member of the original Royal College of Physicians and Surgeons of Ontario, which came into existence in 1856. We are told by the Registrar of the Council that he has attended nearly every meeting since that date. We are told also that Sir James Grant is the only living member of what is known as the Confederation Parliament, that is, the first Parliament after Confederation in 1867.

Sir Arbuthnot Lane and Col. (Dr.) Herbert Bruce, two of the representatives sent by the British Army authorities to the United States and Canada, visited Toronto June 15th, and both were very busy while in the city. They delivered addresses at the Canadian Club, at the Graduating Exercises of Wellesley Hospital and at the Academy of Medicine.

Surgeon-General G. Sterling Ryerson has retired as professor of ophthalmology and otology in the University of Toronto. He is on the Pacific Coast at present, where he has been touring and speaking for the American Red Cross in the North-Western and Pacific States. He expects to return to Toronto in September.

# Appointments as Medical Examiners

The Empire Life Insurance Company of Canada has been formed under Dominion Charter with the special object of granting insurance to under-average lives.

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The Clerical, Medical and General Life Assurance Society of London, England, was organized in Great Britain in the year 1824, with the same object that the Empire Life is founded to-day in the Dominion.

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# Book Review

*Diseases of the Skin, their Pathology and Treatment.* By MILTON B. HARTZELL, A.M., M.D., LL.D., Professor of Dermatology in the University of Pennsylvania. Fifty-one colored plates and 242 cuts in the text. Philadelphia and London: J. B. Lippincott Company, 1917.

A new text-book on diseases of the skin is always of interest, as there is probably no department of medicine in which wider latitude is furnished in regard to the classification of cases and the general handling of the subject matter.

In his general classification the author has adopted simplicity, reducing the number of main classes to eleven, which is in marked contrast to that seen in many text-books.

It is to be noted particularly the importance assigned to etiology and pathology for, as the author truly states, " a knowledge of these must lie at the foundation of all rational treatment and prophylaxis." The correlation of dermatology to general internal medicine is thus made clear, and the importance of a thorough physical examination of the patient emphasized.

In regard to treatment more definite details are given as to exact administration than is usually found, a point that will assuredly be appreciated by the general practitioner

The illustrations are numerous, both cuts and colored plates, and are admirably chosen to accompany the book matter.

We feel sure this book will be well received. It can be heartily commended as a clearly-written, concise and complete text-book of dermatology.

---

### Digitalis and the Blood Pressure

D. Danielopolu (in *Arch. de mal. du cœur*), confirms the fact that digitalis does not raise the blood pressure. His observations cover thirty-six cases, mostly suffering from chronic aortitis. Only three of these showed an increase of blood pressure after the administration of relatively large doses of digitalin. All the others showed a lowering of the blood pressure. Diuresis was increased, and the pulse rhythm steadied and slowed.—*The Prescriber.*

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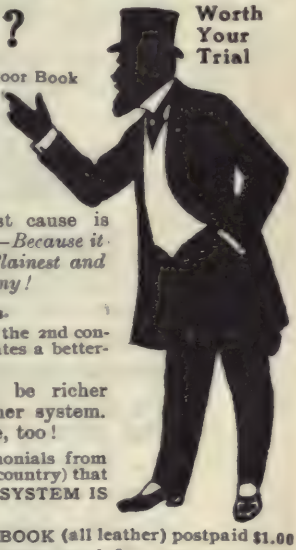

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# Selections

## NURSES WHO HAVE FALLEN

By Olive Dent,
Author of "A V.A.D. in France."

Most military women now entering France, especially if it be the first military visit, go through one particular port. I first passed through the port as a "military" in 1915, and on the threshold of the new life I had a lesson. A chain of circumstances took me to the military cemetery, and I saw for the first time those prim, flat graves, each with its little wooden cross—a sight to stir a newer sense of clearer realization.

Every grave meant a sacrifice. And for what? For freedom—that was a noble cause. For England—that was a mighty one, too. For the weak and defenceless—that spells valor. For English women, for me and women like me. . . .

What had we ever done to deserve this stupendous gift? Why should those unknown heroes be painracked, maimed and die for us? I looked about me in a tumult of emotion, and lying on a grave was a memorial card, among the blurred writing on which one line stood out and attached itself to my thoughts: "Go, labor on; spend and be spent."

. . . . . .

What a message for nursing women! What a message for all English womanhood. I walked to the end of the row of graves and read the inscription on the last wooden cross. The grave was that of a nursing sister. She had paid her debt. She had fulfilled the message. And now she sleeps sweetly on the sentinel hillock among the host of heroes, in the comradeship of the valiant, in the proud kindred of the great dead.

More than three hundred and fifty nursing members have died in the service during the war. A tiny roll of honor, it is true, compared with the greater one. But chivalry still lives, stubborn, tenacious, and we women are shielded from every danger that can be kept from us. We are very proud of our honored roll, proud of the deeds of our dead and the companionship they share. Killed by shell, bomb, torpedo,

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drowning, dysentery, fevers, sickness, cut off in the flower of womanhood, life was very sweet. But they least of all would regret the cause of their going or wish it otherwise.

. . . . . .

Imagine a sun-bathed hillside, receding to a purple blue haze and stretching to a silver-ribboned river, a green film on each levelled brown field, each bush and hedgerow an abiding place of song birds. Round an open grave stand "At attention" nursing women and khaki men, a cordon, a firing party, and a bugler. Under the Union Jack is a rough wooden coffin with a slight girlish burden, and over it come the mellow, dignified tones of the padre in the words of the Burial Service and an address—"Be faithful unto death and I will give thee a crown of life."

Nursing has taught us women many things. It is not in vain that we have been steeped in sorrows, in visions of pain, suffered agonies of human impotence, anguishing realization of human limitations. It is not in vain that we have looked so often on death, for we have grown fearless of it. Clothed in the majesty of renunciation and patriotism, death loses its dread, is bereft of its revulsion.

And women who have known the bitterness of sex, a bitterness newly experienced in 1914, have in nursing and dying on the field, perhaps thousands of miles from home, gained the highest honor and pride of our time. They have become as a soldier.—*Daily Mail* (Eng.).

---

### Boy Scout Hero

Lieut.-General Sir Robert Baden-Powell, in referring to the work performed by the French Boy Scouts in the neighborhood of the fighting line, read a letter found on the body of a dead German. It ran:

> "A traitor has just been shot—a little French lad belonging to one of those gymnastic societies which wear tricolor ribbons (the Eclaireurs, or Boy Scouts), a poor young fellow who in his infatuation wanted to be a hero. The German column was passing along a wooded defile, and he was caught and asked whether the French were about. He refused to give information.
>
> "Fifty yards farther on there was fire from the cover

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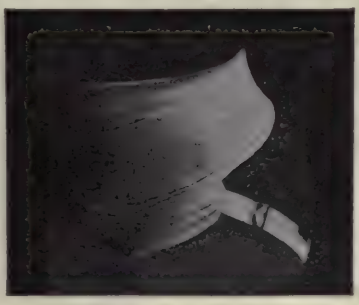

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of a wood. The prisoner was asked in French if he had known that the enemy was in the forest, and he did not deny it. He went with a firm step to a telegraph post and stood up against it, with the green vineyard at his back, and received the volley of the firing party with a proud smile on his face.

"Infatuated wretch! It was a pity to see such wasted courage."

"Was such courage wasted when it acted as an inspiration to the great brotherhood of boys?" Sir Robert asked. The boy faced his death standing like a man, and that was the spirit that was in Boy Scouts all over the world.

---

**Blood Transfusion in Military Surgery**

The most astonishing thing about this brutal military convulsion which is shaking the world to its very core is the magnificent medical efficiency with which the wounded are being treated. The thin line of combat wavers very little or not at all, and the facilities of the medical corps have gradually been approximated to those of the fixed community. Methods peculiar to civil life, which seemingly it would be impossible to utilize when the exigencies of warfare demand long marches and frequent and rapid changes of base, have assumed dominant positions in the surgical repertoire; a marvellous saving of life has resulted. One of these new factors is blood transfusion.

Two of the elements which tax skill in managing military wounds are shock and hæmorrhage. The number of men who have died from these causes is almost uncountable. What better method than transfusion of blood for combating the loss of blood, and for refreshing the exhausted vital centres? A suggestion of the tremendous possibilities of this extraordinarily efficient therapeutic measure has recently been indicated in a report from the British medical services.—*Americal Journal of Surgery.*

---

In diphtheritic croup, fill an atomizer with oil of eucalyptus and oil of turpentine, equal parts, and spray the throat every half-hour; relief in less than an hour.—*Medical Summary.*

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# Miscellaneous

### After the Long School Year

the tired school child, whether girl or boy, is extremely liable to become vitally depressed, worn out both physically and mentally, and more or less anæmic. With the coming of warmer weather, this depreciated condition becomes accentuated, and it is the part of wisdom to take steps to build up the tone of the organism, enrich the vital fluid by creating new red cells, and hæmoglobin, and employ every available means adapted to reconstruct the cells and tissues and restore the depleted vitality. Pepto-Mangan (Gude) does yeoman service in such condition, by furnishing an agreeable, absorbable, and assimilable organic combination of iron and manganese, the agents most needed for blood repair, and general reconstruction. It is pleasant to take, and does not irritate the digestive organs nor cause constipation.

---

### Saccharin and Health

A special committee was appointed in France to investigate the effects of saccharin. The conclusions of this committee (*Bull. Acad. méd.*) were that saccharin, by its antidiastatic action, was liable to interfere with digestion, and that when such an interference, even though slight, was continuous or recurrent, various lesions were threatened. The committee disapproved entirely of the addition of saccharin to food.

Mollière does not favor the too free use of saccharin in place of sugar, and thinks that its sale should be restricted. A certain proportion (one cgm. to the tablespoonful) is admissible in liqueurs, syrups, etc. It should not be used in cakes.

The almost universal use of saccharin in this country to-day shows that its harmfulness is at least much exaggerated. To the ordinary healthy stomach, and especially to the stomach that can digest the various dishes offered at restaurants on meatless days, a single tablet of saccharin cannot do much harm. But when there is any tendency to gastric derangement it might be wise to avoid it, in view of the condemnatory reports received from so many sources.—*The Prescriber.*

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### The Prevention of Venereal Disease

In this country, and more especially in Europe, there has been free and somewhat acidulated discussion as to the best methods of preventing venereal disease. There is no doubt with regard to the prevalence of both syphilis and gonorrhœa, and there is also no doubt that these diseases constitute a serious menace to the public health. All this is recognized by the medical profession at large, but its individual members are at odds regarding the most efficient means of staying the plague. It has been stated on excellent authority that direct prophylaxis on the Metchnikoff plan, if used in time, is a sure preventive, and the records of practical experience appear to bear out the statement. An attempt has been made recently by a portion of the medical profession, to introduce direct prophylaxis into Great Britain or, at any rate, into the army. However, the attempt has met with much opposition based on so-called moral grounds. A controversy is raging at the present time in the

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medical and lay press between champions of personal prophylaxis and those who hold contrary views. The opponents of the method, while allowing that it may be and probably is all that is claimed for it as a prophylactic, take the stand that it is quite arguable that venereal disease may be abolished at too great a moral cost, tragic though the consequences of inaction may be to innocent women and children and the public health generally. The cost referred to is the State recognition and practical encouragement of sexual vice as a necessary evil. On the other hand, the supporters of the method contend that this phase of the question is disposed of by relegating it to instruction by " parents, guardians, priests, deacons, and philosophers," or teachers and governesses. Moreover, the advocates of direct prophylaxis assert that it would not be long ere venereal diseases would be entirely eradicated if such measures were strictly carried out. Dr. Montague Lomax, writing in the *Medical Press,* April 3, 1918, weighs the " fors and againsts " and, although he endeavors to maintain an open mind, it is plain to see that he apprehends many difficulties in the way of making direct prophylaxis general. He does not believe that promiscuous sexual intercourse can ever be physically right. In his opinion " rightness " is a question of morals, and morals alone. An action may be physically natural and yet not physically right. Lomax strenuously contends that chastity, whether voluntary or enforced, does not do a tithe of the harm, personal and social, that results from promiscuous unchastity. While it may be extremely hard from many points of view to reconcile the moral and physical aspects of the case, yet at the same time the fact must be borne in mind that soldiers should be protected, at least during war time, against the contraction of venereal diseases. If direct prophylaxis used in time will prevent infection, then by all means direct prophylaxis should not only be practised among soldiers, but enforced. Good health is essential to the fighters—*Medical Record.*

R38


# The Canadian Practitioner and Review

Vol. XLIII. TORONTO, AUGUST, 1918 No. 8


## Original Communications

### RADIUMTHERAPY IN HYPERTHYROIDISM WITH OBSERVATIONS ON THE ENDOCRINOUS SYSTEM*

By W. H. B. Aikins, M.D., Toronto.

During recent years the increasing use of radiumtherapy in the treatment of pathological conditions of the thyroid gland has given the writer an opportunity to make certain interesting observations on the thyroid itself, and also on its relationship towards other members of the endocrinous system.

The use of radium has been directed more particularly towards pathological increases of function than towards simple enlargement of the gland. The extension of radiumtherapy into this field was first brought about by Dr. Robert Abbe, of New York, in 1905, who by burying radium tubes in the gland itself, in a case of exophthalmic goitre, caused shrinking of the mass and cessation of the symptoms of thyroidism.

Tentatively the writer treated one or two cases of hyperthyroidism some seven or eight years ago with clinical improvement. The permanence of the result obtained in these patients justified one in advocating radiumtherapy for such functional disturbances of the thyroid. In all, forty-five cases have been under treatment, the majority during the past three years. Of these, twenty-three have been clinically cured—that is, the tachycardia, tremor and restlessness have disappeared, and symptoms of excessive thyroid secretion have abated. In seventeen cases there has been an improvement, but not a complete

* Read at the meeting of the American Radium Society, Chicago, June 10, 1918.

cessation of symptoms. Four cases have passed from observation. In only nineteen patients did the thyroid gland itself decrease in size, as evidenced by neck measurement, while in six there was no diminution in the size of the gland, although the nervous symptoms were completely relieved. In three cases thyroidectomy had been performed, but the nervous symptoms had not diminished. This was, however, effected by radiumtherapy.

In connection with the treatment of these cases, it must not be overlooked that general medical measures were carried out as well. In some cases complete bodily and mental rest, in others partial, was established. A low protein diet and one poor in extractives was advised, while the internal administration of quinine hydrobromate, grs. 5, t.i.d., together with ergotin, gr. 1, t.i.d., was prescribed. In a large number of these cases, all these usual medical measures had failed to relieve the symptoms, and it was only when radiumtherapy was added as a therapeutic measure that the hyperthyroidism was lessened.

It is to be noted also that it was only in a percentage of cases that there was decrease in the size of the gland. Surgical measures would be necessary in many to effect this, and yet the nervous condition was such that surgery was a very risky procedure. The relief of the nervous symptoms made it possible to undertake the surgical removal of the goitre for cosmetic reasons later on if the patient wished it.

The occurrence of exophthalmic goitre following the removal of the ovaries in two of the three cases under observation interested the writer in the inter-relationship existing among the organs of internal secretion. These cases may be cited in detail.

### Illustrative Cases.

Blair Bell reports two cases which are extremely interesting from the point of view of the subject we have under consideration. In one of them, a woman of 46, double oophorectomy was done for malignant disease. For the first two months after the operation the patient did well, but then the symptoms of exophthalmic goitre developed, and she died from it within a year of the operation. The second case was that of a woman of 25, who had been perfectly well until the birth of her first child, eleven months before she came under observation. Menstruation did not occur, and all the typical symptoms of exoph-

thalmic goitre developed. In this case the uterus was found to be in a state of super-involution, its length being less than two inches. The pathology of super-involution is still somewhat obscure. He thinks it probable that deficiency of ovarian secretion may play a part in some cases, but that at the same time secretory disturbances of the other ductless glands may lead to a similar condition. The following are details of two cases which have come under my observation.

Case 1. Mrs. K., 35 years of age, who was referred to me in February, 1914, by Dr. Smith, of North Bay. In May, 1913, double oophorectomy was done for a chronic inflammatory condition. In the following November symptoms of hyperthyroidism appeared gradually increasing in severity. She was treated by prolonged rest, the internal administration of quinine hydrobromate, and all the usual medical measures. When I first saw her in February, 1914, there was only slight enlargement of the thyroid, but the pulse rate was 140 and there was marked nervousness and tremor. The treatment was then supplemented by irradiation of the area of the thyroid gland by means of screened plaques of radium. Two weeks later the pulse rate had gone down to 75, nervousness and tremor were less marked, and she was resting well. Further radium treatment was given a month later. There was constant improvement in the symptoms, and she gradually became able to take more exercise and to do light work without distress. She has now resumed her normal life, and has been quite well ever since.

Case 2. Mrs. W. This lady had a pan-hysterectomy performed in August, 1915, for carcinoma of the uterus. A year later she manifested symptoms of hyperthyroidism. She became very nervous and excitable, the thyroid increased in size, the eyes became prominent, and the patient was very much emaciated. The pulse was very erratic, going up to 140 on the slightest exertion. Rest, together with the administration of bromides and quinine hydrobromate, the constant application of an ice bag over the heart, and the radiation of the thyroid gland at intervals, have resulted in most marked and gratifying improvement. The pulse has become steady and quiet, the nervousness, tremor and exophthalmos almost completely disappeared, while she has gained in weight and is now able to perform her ordinary duties.

In the Report of the Manchester and District Radium Institute, Dr. Burrows refers to seven cases of exophthalmic

goitre, all of which were improved by radium. In a subsequent report, published in May, 1917, he says that of a total number of forty cases, twenty-one were considerably improved, but that in most of these sufficient time had not elapsed to estimate the permanent results.

Drs. Gaston Torrance, Gewin and Weed, of Birmingham, Alabama, report a case in which tachycardia rapidly subsided, the thyroid diminished in size and nervousness disappeared. Dr. Lee, of Rochester, also reports a successful case, and says that although exophthalmic goitre, with involvement of the thymus, does not respond to radium so well as to operation, radium brings about great improvement.

Dr. Dawson Turner reports the case of a woman of 69, who had suffered for two years from severe exophthalmic goitre with tachycardia up to and above 170. After other measures, including the x-rays, had been tried in vain, radium brought about rapid improvement, which was maintained.

The idea of a certain functional correlation and interrelationship between different organs and different parts of the body is not by any means a new one, but within the last two or three decades this theory has undergone a considerable amount of development, more especially in regard to the relationship which exists between those organs which are known as the ductless glands or the organs of internal secretion. In spite of the fact that recent investigations, both experimental and clinical, particularly those of Biedl and Blair Bell, have added considerably to our knowledge in this respect, the exact character of this relationship still remains more or less obscure.

Internal secretions were first described by Brown-Sequard at a meeting of the Société de Biologie at Paris in 1889. He showed experimentally that, in addition to nervous intercommunication between the different organs of the body, a process of internal secretion in the nature of a chemical interchange between certain organs is constantly going on. This theory has since been elaborated by several writers, including Bayliss and Starling, Biedl and Blair Bell.

To the ductless glands or organs of internal secretion, which are generally assumed to include the thyroid, thymus, pituitary glands or hypophysis cerebri, the suprarenals, the pineal gland and ovaries, Schafer has given the name of the endocrinous glandular system. He describes an endocrinous gland as one that is known to produce within its cells some specific chemical substance which is passed directly or indirectly into the blood

stream, thus forming the active material of its secretion, in the same way that ptyalin is the active agent of the salivary gland. The endocrinous glands differ from the salivary glands, however, in that their secretion remains within the body, circulating with the blood whereas that of the salivary glands passes by way of a duct to the exterior of the body and is excreted.

The results of the investigations of Biedl and Blair Bell indicate that the individual members of this glandular system are very intimately connected with one another, and that this relationship is dependent on a chemical interchange of their specific secretions, which is accomplished by the intermediation of the blood stream. They indicate further that this interdependence tends to keep the body as a whole in a condition of equilibrium. It is therefore reasonable to suppose that the removal of any one of these organs, or the cessation of its secretion, would be likely to have a more or less deleterious effect upon the others, and tend to upset the equilibrium of the body generally. Blair Bell's observations conclusively prove that this supposition is founded on fact.

### Hormones.

Biedl assumes that the chemical correlation is brought about by means of the active principles of the secretions, which serve as intermediaries between the different organs. Sir Edwin Schafer states that the results of his researches indicate that the action of the active principles of the internal secretions is not unlike that of the active principles of drugs, which also operate by direct action on the parts to which they are conveyed by the circulating blood.

The active principles of the endocrinous glands also resemble drugs, in that extracts of some of them tend to stimulate or excite the cellular functions, whilst others depress or inhibit them. An example of the latter effect is that of injection of extract of placenta, which tends to inhibit the secretion of milk.

The term *hormone,* which is derived from a Greek word meaning to excite or stimulate, was originally applied by Bayliss and Starling to stimulating active principles, such as that contained in extract of duodenum after treatment by acid, and its significance has since been extended to include the active principles of all internal secretions. Biedl and Schafer point out, however, that there are two different groups of hormones. Biedl describes these two groups as assimilatory and dis-

assimilatory, the first conducing to the building up of living tissue, whilst the second favors its decomposition. Schafer describes them as stimulating principles and depressing or inhibiting principles, in that, whilst some of them stimulate function, others depress or inhibit it. Schafer emphasizes the advisability of discriminating between these two groups, and limiting the term *hormone* to those which have a stimulating action. For the depressing or inhibiting agents he suggests the use of the term *chalone,* which is derived from a Greek word meaning to make slack. He defines a *chalone* as an endocrinous secretion tending to inhibit or prevent activity of an organ or tissue, and a *hormone,* on the other hand, as a secretion which excites or stimulates an organ or tissue to increased activity. Biedl is of opinion that the increased functional activity of organs of internal secretion which may follow the suppression of any one secretion, is to be regarded as a symptom of the disassimilation due to this suppression.

### Frequency of Goitre in Women.

The much greater frequency of exophthalmic and other forms of goitre in women, as shown by a remarkable unanimity in the statistics to this effect, definitely indicates the close connection which exists between the thyroid and the genital organs, and the influence of ovarian secretion on the thyroid. This intimate relationship is also obvious from the fact that the manifestations of exophthalmic goitre frequently make their appearance or are aggravated at critical periods in development, such as puberty, during menstruation, and at and after the menopause.

As regards the comparative frequency in the sexes, the returns of the Registrar-General show that during the four years (1911 to 1914) there were in England and Wales 1,613 deaths from exophthalmic goitre, 1,558 of them being women and 155 men, or a proportion of no less than ten to one. Hector Mackenzie has collected 438 cases, 393 being women and 45 men, a proportion of nine to one. In six of his cases the condition followed a prolonged and difficult confinement. Dr. Helen Gurney has made an analysis of 93 cases of exophthalmic goitre, 92.5 per cent. of which were in women. Von Graefe states that his cases were six to one, Trousseau that his were fifty to eight, Henoch that his were twenty-three to four, and

Praelc that his were twenty-one to one. Mr. James Berry, who has had considerable experience in the treatment of exophthalmic goitre, states that in his experience goitre was eight times as common in women as in men. Of 103 cases which he operated upon during 1913, eleven only were in men. In this connection Mr. Berry makes a rather interesting statement. He says that his patients with exophthalmic goitre are very seldom women who have married at an early age and had children. They are, as a rule, either unmarried women, widows, or women who are separated from their husbands, or women who are, in some way or other, not leading a normal sexual life.

### Influence of the Thyroid Gland on Menstruation and Puberty.

The secretion of the thyroid may be either insufficient or excessive. If it is insufficient, puberty may be delayed, or may be followed by secondary amenorrhœa, or scanty menstruation associated with dysmenorrhœa. Blair Bell's researches indicate that if thyroid secretion is deficient, menstruation is either scanty or absent altogether. The influence of thyroid insufficiency in this connection is shown by the fact that such cases are usually cured by the administration of thyroid extract. Many writers, including Biedl and Blair Bell, state that swelling of the thyroid is very common during the menstrual periods. Biedl is of opinion that, though it may be partially due to the general vascular changes which are associated with menstruation, there is no doubt whatever that a general biological relationship exists between the thyroid gland and the ovaries.

Blair Bell, on the other hand, points out that excessive thyroid secretion may act in one of two ways, namely: (1) It may stimulate the genital functions to excessive activity, or (2) it may upset general metabolism to such an extent as to cause them to cease altogether. He says that there is a form of hyperthyroidism which results in excessive menstruation, and which is not associated with any of the ordinary symptoms of exophthalmic goitre. In his experience this excessive functional activity is not infrequently accompanied by menorrhagia. Blair Bell suggests the possibility that this hyper-activity may be due to incomplete development of the ovaries.

As regards the use of the term *hyperthyroidism* to describe Graves' disease, there seems to be some difference of opinion

as to whether this is a very suitable description of it. Berry does not go so far as to assert that Graves' disease is due to thyroid insufficiency, but he considers that such a statement would be quite as accurate as to say that it is due solely to excess of thyroid secretion. In his opinion the idea that it is due to hyperthyroidism has arisen from the fact that the symptoms of excess are so very conspicuous that they completely overshadow the concomitant signs of thyroid insufficiency. Oswald also thinks that goitre, including Graves' disease, should not be regarded as a manifestation of increased thyroid activity, but rather as an indication that the secretion has lost its physiological value and become perverted.

Murray Leslie in a series of cases, observed the effects on menstruation of conditions of a certain degree of hypo thyroidism and hyperthyroidism, and concludes from clinical observation that the thyroid gland possesses two varieties of internal secretion, the one being of an excitory character and the other inhibitory. Some of his cases of hyperthyroidism were associated with profuse menorrhagia, others with partial amenorrhœa. He is of opinion that in cases of obstinate amenorrhœa the ovaries may very possibly be normal, and the thyroid or pituitary responsible for the symptoms. He emphasizes the desirability, from this point of view, of using combined glandular extracts in the treatment of amenorrhœa and other disorders of the genital functions.

### The Thyroid Gland and Pregnancy.

Most of the writers on the subject seem to agree that it is quite a common thing for a woman who is suffering from goitre of any kind to say that it increases in size and causes more discomfort during pregnancy. Blair Bell thinks that this increase of thyroid activity, which in his opinion is most marked in the early stages of pregnancy, takes the form of a storage of colloid material in the vesicles of the gland, and that this storage is probably necessary, owing to the changes in metabolism associated with gestation. He thinks that whilst activity of the thyroid is most marked during the early stages, that of the pituitary gland and suprarenals is most pronounced during the latter stages of pregnancy. Mr. James Berry does not agree that enlargement of the thyroid is most marked in the early stages, as in his experience enlargement of the gland and dyspnœa usually occurred in the later months.

As regards excessive thyroid secretion, Blair Bell is of opinion that it does not affect fertility unless the patient is in an advanced stage of Graves' disease. If pregnancy occurs in a case of marked exophthalmic goitre, which it rarely does, he recommends the administration of large doses of calcium salts, owing to the tendency to post-partum and ante-partum hæmorrhage. Whilst he is unable to say positively whether or not pregnancy is capable of causing exophthalmic goitre he has certainly met with several cases in which its onset occurred during pregnancy, and has found pituitary extract very useful in such patients.

Louise McIlroy has seen a previously cured goitre recur on the onset of pregnancy. She concludes that the enlargement of the thyroid during menstruation and pregnancy is probably due to the added strain which pregnancy throws on the organism, and the toxins developed by the ovary or the embedding ovum. The thyroid, in an attempt to counteract this state of things, takes on added toxins.

Blair Bell points out that it has sometimes been said that ovulation ceases during pregnancy. If this is so, it may indicate that the insufficiency of ovarian secretion throws a considerable strain on the other organs of internal secretion, such as the thyroid and pituitary glands, and may therefore result in hyperplasia of these organs.

### The Thyroid and the Menopause.

Blair Bell is of opinion that deficiency of ovarian secretion, except when due to the natural or artificial menopause, may most often be traced to abnormalities in the more distant endocrinous glands. It is easy to understand that the psychic and nervous symptoms, which are usually associated with the natural menopause, result from the loss of the ovarian secretion, which upsets the balance of correlation between the glands of internal secretion and also from the changes in these glands which occur at this period, notably the thyroid and pituitary. It is a well known fact that intravenous injection of thyroid extract tends to lower blood-pressure at the menopause.

In this connection Murray Leslie refers to the hypothesis advanced by Grünbaum and Ehrlich of the possibility of there being some connection between the growth of cancer in women and defective correlation of the internal secretions. Ehrlich assumes that normally certain substances are present in the cir-

culation, derived from the internal secretions, and that these substances may possibly possess the property of stimulating the body cells to resist the cancer cells. If this is so, one would naturally expect the common incidence of cancer in women after the menopause, and its occurrence in earlier adult life might possibly be due to defective correlation of the endocrinous glands. In support of this hypothesis Murray Leslie reports a case of inoperable cancer in a woman of 28, who six months previous had developed amenorrhœa, with the appearance of hair on the face and body.

### Effect on the Genital System of Removal of Thyroid.

If the endocrinous glandular system is in such intimate relationship as would appear from what has been said, we should naturally expect that, on the one hand, complete removal of the thyroid would have an influence on the genital system, and that, on the other hand, the removal of the ovaries would have a corresponding effect upon the thyroid. The results of investigation show that this is the case.

According to Leonard Williams the thyroid performs the following functions: It presides over the nutrition of the skin and its appendages and has a powerful influence on general metabolism, especially calcium metabolism. It is concerned in the development and building up of the body, the development and maintenance of the sexual functions, and in the maintenance of the body temperature. It is one of our chief defences against toxic invasion, is essential to the proper working of the nervous system, especially the higher functions of the brain, and reinforces or antagonizes the action of the other ductless glands, especially the genital glands.

It is therefore not to be wondered at that removal or atrophy of an organ of such universal importance should have a profound effect upon the harmonious correlation of the internal secretions. Blair Bell's experiments showed that after complete removal of the thyroid there is as much muscular atrophy of the uterus as is seen after oophorectomy, both in pregnant and non-pregnant animals. Changes also occur in the suprarenals, and there is increase in secretory activity of the pituitary body.

In women thyroid insufficiency affects the genital functions in proportion to its degree. Marked insufficiency, such as is seen in myxœdema, almost invariably leads to sterility. Ex-

cessive thyroid secretion is not infrequently associated with pathological conditions in the pelvis, but in such cases Blair Bell emphasizes the importance of distinguishing between those resulting from and those which are the cause of genital affections.

### Effect of Oophorectomy on the Thyroid.

We therefore see that important changes occur in the genital system as a result of complete removal of the thyroid, and the investigations, both experimental and clinical, of Blair Bell and others show that double oophorectomy leads to profound alterations in the thyroid and other endocrinous glands, affording further proof of the close relationship which exists between them and the ovaries. Blair Bell found that in the rabbit experimental removal of the ovaries resulted in greatly increased functional activity of the thyroid, as shown by the production of colloid material, with which the vesicles of the gland became greatly distended. This newly-formed colloid material differs from normal colloid material in that it is basophile and stains blue with hæmatoxylin, whereas normal colloid is acidophile and stains pink with eosin. Blair Bell says that he cannot account for this particular alteration in reaction and staining, but he suggests the possibility that the colloid produced after oophorectomy may represent a storage secretion, formed to meet the alteration of metabolism. He is of opinion that the enlargement of the thyroid seen in pregnancy corresponds to a certain extent with that occurring after oophorectomy. He has known more than one case of exophthalmic goitre commence during pregnancy, and in view of the results of his investigations he thinks it is amply proved that insufficiency or absence of ovarian secretion leads to changes in the thyroid which may in comparatively rare cases result in exophthalmic goitre. Louise McIlroy also says that it is a well-known fact that goitre sometimes follows oophorectomy.

In addition to producing changes in the thyroid, oophorectomy seems also to influence the other endocrinous glands. Blach and Hulles report atrophy of the pineal gland in their whole series of cases. In the suprarenals of rabbits and cats Blair Bell found a definite increase in the reticulated portion of the cortex at the expense of the zona fasciculata, together with temporary increase in secretory activity of the anterior lobe of the pituitary gland. His researches lead him to con-

clude that the changes in the other ductless glands after removal of one of their number are sometimes compensatory, and represent an attempt to correct the disturbances of general metabolism.

### The Importance of Calcium Metabolism in this Connection.

Calcium salts are of great importance in the human economy. In early life they are chiefly used for building up the bony skeleton, after puberty they participate to an important extent in the processes of reproduction, and in late adult life they are largely concerned in bringing about the pathological changes associated with sterility, due to the retention of calcium salts in the tissues, especially the arteries. The various internal secretions directly influence calcium metabolism in one way or another, some of them, such as those of the suprarenals and the pituitary gland, tending to produce retention of calcium salts in the blood and tissues, and others, such as those of the thyroid and ovary, tending to induce excretion of these salts. This fact is the basis of the treatment of hyperthyroidism by pituitary extract, which has been recommended by Blair Bell. This treatment is on the principle that it is a normal function of the suprarenals and pituitary gland to antagonize the action of the ovaries and thyroid and thus maintain equilibrium in calcium metabolism. Blair Bell has come to the conclusion that the effects on the thyroid and other endocrinous glands after removal of the ovaries are due to the upsetting of the balance of calcium metabolism by the absence of the ovarian secretion. In animals there is marked retention of calcium after oophorectomy, with increased excretion of phosphorus and nitrogen.

### Influence of "Femininity" on the Severity of the Symptoms After Oophorectomy.

In discussing the question of the advisability or otherwise of indiscriminate oophorectomy Blair Bell explains the great variations in the severity of the reaction to it, and also to the natural menopause, by the degree, in individual cases, of what he describes as "femininity," which he says normally varies within wide limits. In other words, femininity indicates the previous functional activity of the genital system, especially of ovarian secretory activity. He is of opinion that the severity

of the symptoms following oophorectomy and the natural menopause is directly proportionate to that degree of femininity, and thinks that the ignoring of these individual variations accounts for the conflicting opinions expressed by surgeons, some of whom state that it produces little or no disturbance, whilst others describe severe reactions and distressing nervous and psychic symptoms. He suggests the possibility of estimating the degree of femininity before operation, and thinks that in many cases it would not be difficult to do so. If femininity and ovarian activity were found to be decidedly below the average it might be possible to assert that little disturbance was likely to result from the operation, but unless this distinction can be made he does not think it right to perform oophorectomy indiscriminately. In the discussion which followed the reading of Blair Bell's paper Dr. Murray Leslie said that he strongly supported the view of the relationship between femininity and the secretory activity of all the endocrinous glands.

### Importance of all Internal Secretions as a Whole.

Enough has been said to indicate most unmistakably that there is an intimate and most remarkable relationship between all the organs of internal secretion, and that they one and all play an important and essential part in the process of development and reproduction. This is shown above all by the alterations in the thyroid and other ductless glands which follow oophorectomy, and on the other hand by those in the genital organs, especially the atrophy of the uterus, which result from complete removal of the thyroid. Total ablation of either the ovaries or the thyroid results in profound changes in general metabolism. Biedl points out that, on the one hand, hyperthyroidism leads, as in Graves' disease, to functional changes in the ovaries, and that, on the other hand, primary changes in ovarian activity may secondarily affect the thyroid and thus influence the development of the symptoms of Graves' disease.

Blair Bell emphasizes the importance of all the endocrinous glands in the development of the genital functions, and points out that although the genital organs may be perfectly normal, morphologically they fail to become functionally active at puberty unless the whole of the endocrinous system is in perfect correlation and functioning harmoniously as a whole. Devel-

opment of the genital organs appears to be dependent upon general metabolic conditions regulated by the influence of all the endocrinous glands. Blair Bell also points out that what he describes as "femininity" is itself dependent upon the correlation of all the endocrinous organs, and not upon ovarian secretion only. He regards the ovaries as part of a system, "to which most, if not all, the other endocrinous glands belong," and that these latter organs are of as great significance in relation to the reproductive functions as the ovaries themselves. The exact role played by the individual members of this system still remains more or less obscure, and we do not yet know to what extent excessive calcium retention, due to ovarian insufficiency, may be compensated for by thyroid secretion. On removal of the ovaries or their atrophy at the menopause the reproductive functions of the remainder of the endocrinous system cease, and the harmony of the system is naturally disturbed. In this event it is obvious that the individual must suffer if compensation or readjustment is not speedily and satisfactorily re-established.

If the connection between the ovaries and the other ductless glands is so intimate as is assumed by Blair Bell and others, it would indeed appear advisable to take this correlation into consideration before deciding to perform double oophorectomy; as we should have to consider the effect of the operation, not on the genital system alone, but also on the other ductless glands. Blair Bell says that in future "those who are interested in gynæcology may come to look upon all the ductless glands, in that each one of them is absolutely indispensable to the harmony of the genital functions."

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# Editorials

## FOOD AND THE WAR

The phrase that food will win the war is, from its constant repetition, becoming almost monotonous. But it is absolutely true, and it is also well that the fact should be dinned continually into the ears of the members of the population of this continent "lest they forget" and do not practise that thrift and conservation which will alone render it possible for food to play its part in bringing about victory.

The community at large must be educated as to the food value of different articles of diet, and must be taught that many of their hidebound notions with regard to food are wrong, or, at any rate, based upon incorrect premises. Ignorance in this direction is widespread, indeed, few people have right conceptions of the influence of diet upon health and disease. Food is the most important factor in the preservation and maintenance of health, and is generally, perhaps, of greater avail than drugs in the treatment of disease.

It follows then that as, in the present juncture, food is of incalculable importance, every means should be taken to disseminate knowledge of the subject both from the scientific and practical standpoint. The June number of *American Medicine* represents a successful attempt to present to the medical profession and to the public a comprehensive survey of the scientific and practical aspect of the food situation. In this number there are twenty papers contributed by authorities on food and diet in Great Britain, the

United States and Canada. Among the articles to which special attention may be called are those on "Dehydration," by Major W. E. Fitch, M.D., M.R.C., U.S.A.; on "The Place of Milk and Vegetables in the Diet," by Professor H. C. Sherman, of Columbia University, New York City; on "Milk-butter, Fats, Nut-butter and Oleomargarine for the Child," by Dr. George Dow Scott, of New York City; on "Diet after Forty," by Dr. Adam H. Wright, of Toronto; on "Pasteurization of Milk," by Dr. Chas. J. Hastings of Toronto; and on the "Vitamines," by Dr. A. Bruce Macallum of Toronto. All the subjects discussed in the above-mentioned articles are obviously of surpassing interest, subjects concerning which it behooves the public to become as thoroughly acquainted as possible and as quickly as possible. Within the scope of a brief editorial, it will be impossible to do more than touch upon these questions. It may be said, however, that dehydration of food and of vegetables and fruit in particular, when done properly, bids fair to revolutionize the entire food situation, and is peculiarly applicable to war conditions. It is needless to lay stress upon the place that milk and vegetables fill in the diet. Professor Sherman has dealt with this matter in the most illuminating way. Dr. Scott has pointed out the value of the nut-butter fats and oleomargarine, and has shown how effectively they serve as substitutes for milk-butter fats in the feeding of young children. Dr. Adam Wright has preached the gospel of temperance, even of frugality in eating and drinking after the age of forty, and has driven home the truth so frequently neglected, that a large proportion of individuals dig their graves with their teeth. Dr. Hastings has

shown, as few men could show, the value of pasteurization, giving eleven convincing reasons why milk should be pasteurized. Dr. Macallum has concerned himself with discussing the essential part which the vitamines play in the diet, a matter of which the general public is profoundly ignorant, and regarding which it requires enlightenment.

The contents of the food number of *American Medicine* should be made widely known. It is educative in a high degree, and is the kind of literature that is needed in existing circumstances.

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## THE RAMSAY GIFT

Mr William Ramsay was for many years one of Toronto's most highly respected citizens. During the last thirty years he lived in Bowland, Midlothian, Scotland, but during that time made many visits to Toronto.

We learn from the daily press that he had made a princely gift to Toronto, in the shape of property valued at about $500,000, which has been placed in the hands of the Toronto General Trusts Corporation, who will act as trustees.

The trustees are to sell the property when they think fit, and then invest the proceeds. The net income will be distributed as follows: Two-fifths to the Toronto General Hospital, one-fifth to the Home for Incurables, and the other two-fifths to be distributed among Toronto charities as the trustees decide.

It is not known when the charities will begin to realize from the gift. It is possible the trustees may

decide to invest the present income, which is actually small at present, towards improving the property before selling. The result of such a deal would probably be the increase in the revenue which the various charities would receive as compared with what they would get if the property were sold immediately.

## MEDICAL STUDENTS IN MILITARY SERVICE

It was recently announced in Ottawa that Medical and Dental students in Class "A" will be expected to fulfill the necessary requirements. They must report for duty at the depot battalions, and then will be transferred to the A.M.C. training Depot in the district in which they have reported for duty during any regular or special session in a medical college. They will be "on command" by their unit, will receive pay, wear uniforms, and be subject to military law.

## CANADIAN MEDICAL ASSOCIATION

We understand that the officers of the C.M.A. are well satisfied with their share of the large meeting in Hamilton. The *C.M.A.J.* speaks very highly of the work done by the Local Committee, but in its issue for July was unable to say how many of those present were members of the Canadian Association, because of the complexities connected with the system of registration adopted.

The members present were more than pleased to meet their new President, Dr. H. B. Small, of Ottawa, who has for many years worked faithfully in the interests of the Association.

Great interest was taken in the museum and laboratory section. The specimens from the C.A.M.C. museum were sent to Hamilton by special permission of Surgeon-General Fotheringham, D.G.M.S. In accordance with the resolution, unanimously passed, a statement of appreciation was sent to Dr. Fotheringham, with the recommendation that it be forwarded to the Minister Overseas.

Everyone was well pleased to hear that the next meeting will be held in the City of Quebec. There was also a cordial invitation from Halifax. It was not easy to choose between these cities, and while Quebec was chosen, the hope was expressed that Halifax would extend another invitation either next year or in the near future.

Dr. S. E. Grondin was unanimously elected President. Those who know him say that he is the man for the position, and with the help of his numerous friends will certainly make the meeting a great success.

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## FEDERAL BUREAU OF HEALTH

By an Act passed in 1868, it was declared that the administration of public health is joint between the Dominion and the Province, in virtue of the Act of Confederation. It is not generally known that there was a Federal Bureau of Public Health from 1868 to 1872, the late Dr. Tache being Secretary.

It was thought by many that it should have been

continued, and such parties all desire a re-establishment as soon as possible. The Canadian Medical Association passed a strong resolution in its favor in 1902, and sent many deputations and resolutions to the Government at Ottawa during the last sixteen years. Nearly all the other medical associations of Canada, and many women's societies, have indicated very clearly their desire for such a Bureau.

There happens, however, to be a complex situation at Ottawa. The control of matters pertaining to public health is at present divided among the following departments: Agriculture, Interior, Inland Revenue, Marine and Fisheries, Commission of Conservation, and all branches of the Department of Militia. To join all these departments under one head appears to be a difficult task, which the Government at Ottawa appears afraid to undertake.

Dr. Michael Steel has twice in Parliament moved for the establishment of such a Bureau, and on each occasion the motion was quietly shelved, with little or no explanation of any kind.

(Since the above was written, we have been informed that a strong committee at Ottawa is investigating, and it is now hoped that the Government will consider the matter next session.)

# News Items

### Fifth Year Results Faculty of Medicine

The University of Toronto Faculty of Medicine examination results in the fifth year are as follows: Pass—J. A. Alton, R. H. Baker, O. F. Banting (Clinical Oto-Laryngology), W. B. Barnes, G. A. Bentley, W. H. Cunningham, R. J. M. Fleming, L. R. Gamey, C. T. P. Garbutt, J. V. Hughes, H. O. Jones, W. R. Lane, G. J. Lunz, D. McCallum, J. T. McCosh, F. P. McNevin, A. W. Macpherson, L. C. Rymal, R. M. Tucker, A. W. Valens.

P. D. McIntosh, of the third year, is granted Aegrotat standing in Anatomy, Physiology, Pharmacology, Pathology, Pathological Chemistry, but is required to take examinations in the subjects of Clinical Medicine and Clinical Surgery before proceeding with his fourth year.

### Hospital Ships

Another hospital ship has been destroyed by the Huns. The *Llandovery Castle,* of 11,000 tons, had been chartered by the Canadian Government and had been carrying wounded and sick from England to Canada for several months. On the night of June 27th she was torpedoed while on her way from Halifax to England. There were on board about 80 Canadian medical officers and 14 female nurses. Most of the doctors and nearly all of the nurses were lost.

### Health in Ontario

During the month of June, 2,256 cases of communicable disease were reported to the Provincial Board, while the number in June, 1917, was only 1,133. Among such diseases the most numerous were from scarlet fever, whooping-cough and measles. Fortunately, however, diphtheria appears to be decreasing, there being 136 cases reported this year, compared with 215 in June, 1917.

### Memorial for Dr. Young

As formerly announced, Dr. William D. Young, who died January 4th, after a very short illness, was a remarkable character; always willing to make any sacrifice for his suffering patients, in a large proportion of cases, without any hope or wish for reward. Under the circumstances no one is surprised that he was universally loved at Kew Beach. Shortly after his death his old patients and friends decided to erect a Memorial Fountain in Kew Beach Park to the memory of him who was known as "the beloved physician of the Beaches." The committee in charge has collected $3,000, has selected a site in the park, and has made all arrangements for the erection of the fountain.

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### Home for the Aged

An interesting and remarkable story comes from North York regarding the Newmarket Home for the Aged. It has 70 acres of land, nearly all cultivated. The 71 inmates, 49 men and 22 women, do all the work on this farm, with the help of one teamster. Last month the institution was self-sustaining. The inmates are well fed, well housed, and contented. Can any other institution in America show an equally good record?

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Dr. J. P. Rankin, a prominent physician of Stratford, was fined $50 for alleged infraction of the Ontario Temperance Act. He gave a man named Ovington an order for a quart of whiskey, with directions to take a certain quantity at bedtime for nervous debility. The man, instead of obeying orders, went to London and got drunk. Doctors Quinlin and Stanley considered that Dr. Rankin was justified in giving the prescription. Dr. Armstrong, of Mitchell, opposed alcohol for patients. In the report which appeared in the daily papers no reasons were given for the decision of the magistrate.

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Work on the Rosedale Military Hospital, Toronto, commenced July 15th. On that date the builders commenced putting the main college buildings in shape for hospital accommodation, and fitting up the offices for administration. It is

stated that Toronto will become the largest demobilization centre in Canada.

It is expected that in a few months the rising ground north of the Military Hospital will be the home of 2,000 soldiers at a time, in various stages of convalescence, waiting for their discharge from the army. The number of men on these heights, together with those in the hospital proper, will mean a military population of several thousand in that section for some years to come.

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Dr. Shaver, of West Hamilton, was fined $50 and costs, at Dundas, July 18th, for what was termed a technical breach of the Ontario Temperance Act. He made out a prescription for liquor for a Mrs. Mills, we understand in good faith. She, however, instead of taking it as prescribed, drank the whole quantity at once, and became drunk. Her husband stated that in consequence of her fondness for liquor he had endeavored to keep it from her.

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Sir Robert Borden went to Joinville le Pont, July 3rd, and met President Poincare, and formally presented him on behalf of Canada with a fully equipped Canadian Hospital. It has now accommodation for 520 beds, which will soon be increased to 1,040. General Currie, Commander-in-Chief of the Canadian Armies, and several other prominent Canadians, were present.

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Two important events occurred in London, Ont., July 10th. Sir William Hearst declared open the new Nurses' Home of the Queen Alexandra Sanitarium, the gift of Sir Adam and Lady Beck, as a token of gratitude for the recovery from a serious illness of their daughter Marion. It will be known as the Marion Beck Home.

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Prof. Pozzi, the distinguished surgeon, of Paris, was murdered in his consulting room, June 13th. His murderer, who immediately afterwards committed suicide, was a man upon whom Pozzi had operated about two years ago, and his grievance was that he would not operate upon him again. Prof. Pozzi was born in Bergerac in 1846.

At the meeting of the Royal College of Surgeons in Ireland, May 25th, which was attended by the Lord Lieutenant and Lord Chancellor of Ireland, the Honorary Fellowship was conferred upon Major (Dr.) Harvey Cushing, Professor of Surgery in the University of Harvard.

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A Fourth Medical Board of Review has been appointed for the Toronto Military District. Lieut.-Col. Horace Bascom, Capt. C. E. Fissett and Capt. R. J. Gibson, all of the C.A.M.C.

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Sir James Lougheed declared open the New Vocational Training Building, which, when finally completed, will cost about $500,000.

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The Toronto *World* is inclined to think that the death of the late Sultan of Turkey "was assisted if not personally conducted."

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"There are men and classes of men that stand above the common herd; the soldier, the sailor and the shepherd not infrequently; the artist rarely; rarelier still, the clergyman; the physician almost as a rule. He is the flower of our civilization; and when that stage of man is done with, and only remembered to be marvelled at in history, he will be thought to have shared as little as any in the defects of the period, and almost notably exhibited the virtues of the race. Generosity he has, such as is possible to those who practise an art, never to those who drive a trade; discretion tested by a hundred secrets; tact, tried in a thousand embarrassments; and what are more important, Herculean cheerfulness and courage. So it is that he brings aid and cheer into the sick room, and often enough, though not so often as he wishes, brings healing."—*Robert Louis Stevenson.*

# Personals

Lt.-Col. (Dr.) Thompson, M.P., Yukon, visited Toronto July 9th.

Col. Fraser, of Ottawa, has been appointed A.D.M.S. of the Petawawa Camp.

Dr. H. K. Detweiler, of Toronto, was married to Miss Williamson, of Simcoe, June 20.

Colonel (Dr.) Clarence Starr went to Jackson's Point, Lake Simcoe, July 9th, for a short holiday.

Major J. S. Matheson, for some time Senior Medical Officer at Buxton, England, has been transferred to No. 3 Canadian Hospital, at Etaples.

We are glad to announce that among those honored last King's Birthday was Colonel A. Primrose, Toronto, who was made a Companion of the Bath.

Dr. C. A. MacKay left Toronto June 20th for St. John, where he will act as Medical Director for the Invalided Soldiers' Commission in New Brunswick.

Dr. Geo. F. Butler has accepted the position as Director of the North Shore Health Resort at Winnetka, Ill., and will commence his active duties there September 1st.

Dr. E. L. Hodgins, who was for some time on the active staff of the Toronto Free Hospital for Consumptives, left for the Pacific Coast, where he has taken up private practice.

President Falconer, of the University of Toronto, has gone to England to act for a time as one of the instructors of the Khaki University, the overseas college for Canadian soldiers.

Lieut.-Col. J. A. Hutchinson, of Montreal, has been appointed Consulting Surgeon to the Canadian Army Medical Corps, in the place of Col. George Armstrong, who recently returned to Canada.

Dr. H. S. Birkett, Dean of the McGill Faculty of Medicine, was unanimously elected President of the American Laryngological and Otological Society at the meeting in Atlantic City, May 25th.

Dr. Ernest Hall, of Victoria, B.C., has offered to supply The Royal Jubilee Hospital with his own electrical equipment free of charge, and has also undertaken to supply the service of a qualified medical electric expert for one-half day each week for the treatment of returned soldiers.

Sir Edward Kemp, Overseas Minister of Militia, after his inspection of the Canadian Army Dental Corps, stated that Canada was the first to develop an army of dentistry, and that lately all other allied nations have followed her lead.

After Col. C. A. Hodgetts resigned from his position as Canadian Red Cross Commissioner, Lady Drummond, of Montreal, became Assistant Commissioner. Her work had been warmly commended by Colonel Hodgetts before he resigned.

Hon. Dr. Beland, after his release, remained longer in Holland than was expected. We learn from a cable report that he reached England July 3rd. He stated that his treatment by the enemy had been courteous, and he would have little to complain of if he had been allowed to visit his wife before her death. While a prisoner he was confined for three years in the City Fortress of Berlin.

Colonel (Dr.) Clarence Starr returned to Toronto July 5th. He expresses the opinion that a large part of the surgery of the war is distinctly orthopædic. The Government, recognizing this fact, is establishing five Orthopædic Hospitals in Canada, to be located at Halifax, Montreal, Toronto, Winnipeg and Vancouver. The main orthopædic centre for the Dominion will be in the building at the corner of Dupont and Christie Streets, with a capacity of 1,500 beds.

# Obituary

## DR. MITCHELL

Dr. Mitchell, who for two years was attached to the Hospital for Insane, Queen Street, Toronto, died somewhat suddenly at the General Hospital. He was born at Meaford, Ontario. He had exceptional ability, and his friends pictured a brilliant future for him. Although he suffered from ill health for some years, he was in certain ways very active, and after leaving the Toronto Asylum he acted for a year as a Medical Officer in the Navy.

## HUGH CAMERON, M.D.

Dr. Hugh Cameron was one of Nova Scotia's greatest citizens for a long time, and was member for Inverness in the House of Commons for twenty years. He was for a time the youngest member of the First Canadian Parliament, and, after the death of Sir Mackenzie Bowell, the last survivor among those in Parliament immediately after Federation. He was 82 years of age.

## HENRY C. R. WALKER, M.D.

Dr. Walker died at his home, Wetaskiwin, Alta., July 12th, aged 50. In his boyhood days he lived in Ontario, and received his medical education at Trinity Medical College, Toronto, graduating M.D. in 1895. Soon after graduating he went to the Northwest, and remained in practice there up to the time of his last illness.

## W. HALE, M.D., D.S.O.

Dr. W. Hale, who went overseas as medical adviser of the 42nd Battalion, and greatly distinguished himself by bravery at the front, was accidentally killed in France on or about June 15th. He graduated at Queen's University, Kingston, and practised for a time at Utica, N.Y.

### COLIN McLARTY, M.D., M.R.C.S., Eng.; L.R.C.P., London

Dr. C. McLarty, one of the oldest and best known practitioners in Western Ontario, died at his residence, St. Thomas, June 25. After graduating from Toronto University in 1875, he took an extended post-graduate course in London, and received the "double qualification" in 1876.

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### GUY ELLISTON, M.R.C.S., Eng.

We have to announce with deep regret the death of Mr. Guy Elliston, April 15th, at the age of 46. He became Assistant Secretary to the British Medical Association, and Manager of the *British Medical Journal* in 1898, and Secretary of the Association in 1902.

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### JAMES HENRY LOWE, M.D.

Dr. J. H. Lowe, of Haileybury, died at the General Hospital, Toronto, June 27. He graduated in 1878 and practised for a time in Englehart before going to Haileybury.

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### J. P. SIVEWRIGHT, M.D.

Dr. Sivewright, of Chatham, died suddenly from apoplexy, June 21st, aged 65. He graduated in 1876, and practised in Chatham for over 40 years.

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### BOYLE TRAVERS, M.D.

Dr. Travers, the oldest physician in the Province of New Brunswick, died at his home in St. John, April 7th, aged 94.

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We have to announce with deep regret the death of Lieut. Wilfred Tait, of the Royal Air Force, which occurred at Leaside Aviation Camp, July 16th, while he and a skilled air mechanic were testing an engine in an æroplane. The engine stalled, causing the machine to side-slip to the ground from a height of about 100 feet. On striking the ground the airplane burst into flames and both men were so badly burned that they died before the arrival of assistance. Lieut. Tait was the eldest son of Dr. Nelson Tait, 620 Spadina Avenue, Toronto, and was aged 20.

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Mrs. Jones, wife of Dr. Warner Jones, 41 Avenue Road, Toronto, died at Bala, Muskoka, July 12th.

# Selections

## ERYTHEMA NODOSUM

By Professor Marfan, M.D.

Physician to the Hospital des Enfants Malades, Paris.

This little boy, about three weeks ago, developed an eruption on his legs at a time when he was apparently in the best of health, and was attending school. All that he complained of was pain in his legs, especially when he walked about much. This led his mother to examine him, and she noticed some "pimples" on the front of the legs. The eruption was well marked, and it was easy at a glance to diagnose it as erythema nodosum.

The eruption in question consists of raised, hard, red, often livid patches embedded, as it were, in the dermis. These nodules vary in size; some of them are the size of a pea or a cherry, but some are much bigger. The characteristic features are the hardness that is felt on palpating them, their situation *in* the dermis, and their cyanotic color. To be remarked also, the eruption is fairly symmetrical.

The eruption is not necessarily limited to the legs. Similar nodules are met with on the upper limbs and over the elbows, as well as above and below them. If we examine this region in our little patient we do, as a matter of fact, find several nodules of the kind in that situation.

Now the patient was attacked, as mentioned, while in apparently good health. He was born at term, was the first child of a healthy mother who had never had a miscarriage, and his father is also in good health. The child had never been ill, and is not subject to cough. Even now the only thing he complains about is the pain in his legs.

Now for a long time erythema nodosum was classed among the rheumatic eruptions alongside polymorphous erythema and rheumatoid purpura. This group of pseudo-exanthematous diseases ascribed to the rheumatic diathesis has gradually been dislocated. Polymorphous erythema and rheumatoid purpura constitute two distinct and separate groups. As for erythema nodosum, it has been shown to be a disease standing in some sort of relationship to an acute outbreak of pulmonary tuberculosis. Erythema nodosum only occurs in tuberculous sub-

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P.—4

jects, usually in those in whom the infection is still latent. It is the outward and visible manifestation of slight, septicæmia, attenuated, curable tuberculosis, but is assuredly of bacillary origin.

Our views concerning this affection have, therefore, undergone a radical change, and its treatment must be approached on quite other principles. In times gone by it was thought to be of rheumatic origin, a manifestation of neuro-arthritism, consequently the patients were dieted rather severely. Clinical and biological research, however, have upset this theory. Poncet and his school, especially Landouzy, have provided clinical evidence of the bacillary origin of erythema nodosum, as follows:

If we read the classic descriptions of ancient authors, it will be seen that the development of erythema nodosum entails a certain degree of fever, 38°-39°, accompanied by pain in the joints and muscles, described as rheumatoid, also with a certain degree of furring of the tongue. Then, in the course of three or four weeks, we are told, the patient completely recovered. Many practitioners, however, have remarked that recovery was neither as rapid nor as radical as we are asked to believe; that convalescence, as a matter of fact, is often interrupted or followed by certain accidents.

I remember, for example, the case of a child convalescing from erythema nodosum whom I had sent to the seaside to recuperate, and who returned suffering from pleurisy, with effusion of bacillary nature. In other instances children who have had erythema nodosum remain pale and emaciated, and linger on until one day they are attacked by tuberculous meningitis. Others, again, have developed coxalgia or white tumor of the knee after recovering from their erythema nodosum. At the Rheims Congress, Prof. Landouzy did not hesitate to assert that as a general rule erythema nodosum was invariably a manifestation of bacillæmia.

Experimental observation, on the other hand, confirms these clinical data. The inoculation of fragments of the erythematous tissue in animals rendered them tuberculous, and the histological structure is that of typical "tubercles." Then, too, not only is the cuti-reaction positive on these subjects, but we can provoke the formation of an exactly similar nodule by employing Mantoux's procedure of intra-dermo-reaction, which consists in injecting a minute quantity of diluted tuberculin into the dermis.

Erythema nodosum, then, is under the dependence of a bacillæmia, which can, of course, be recovered from, but which

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is none the less an outbreak of bacillary infection. The diagnosis offers no difficulty whatsoever.

The treatment will, of course, be based on these new views. Instead of subjecting the victims of erythema nodosum to a regimen intended for neuroarthritics, comprising restrictions as to meat and nitrogenous elements of food, they must be put forthwith on an anti-tuberculous diet, viz., raw meat, lime products, residence in the open air in the country, repose, and plenty of fresh air.

These subjects must be regarded as candidates for ordinary tuberculosis, and their habits of life arranged accordingly. The treatment of the acute phase will be that of any acute superficial tuberculous affection, *e.g.,* pleurisy. As there is some fever, salicylate of soda is useful. The patient should be confined to bed as long as the temperature remains above 37.5, and he should be given 40-centigramme doses of the salicylate three times a day. His diet should consist of milk, soups, beef tea, purées, farinaceous articles, cooked fruit, and milk. As soon as the fever has subsided, plenty of meat and eggs.—*Medical Press.*

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## LOOSE SURGERY

Under this heading the *Journal-Lancet* of February 15, 1918, reminds us that some months ago a celebrated surgeon wrote a very valuable article on unnecessary surgery, and he included in his paper many remarks which refer aptly to the loose methods of some surgeons. He admitted that there are many good, conscientious, reliable surgeons, and, furthermore, he stated that that there are a number of men who are rather hasty in their judgments, and will operate on almost anything that will lie still, whether an operation is really necessary or not.

This situation has been before the profession for a long time, and any comment upon the attitude of certain surgeons seems to make no difference in their surgical methods. Undoubtedly there are many cases that look surgical, particularly to a surgeon, when not surgical; and these patients are often hurriedly and without careful investigation, rushed into a hospital to be operated on, the case to be diagnosed after the operation. Such a course takes away the keenness and education of the surgical diagnostician. He should be the man that we may rely upon, first, to make a surgical diagnosis, and then to decide whether operative interference is necessary or not.

We are obliged again to refer to the more careful investiga-

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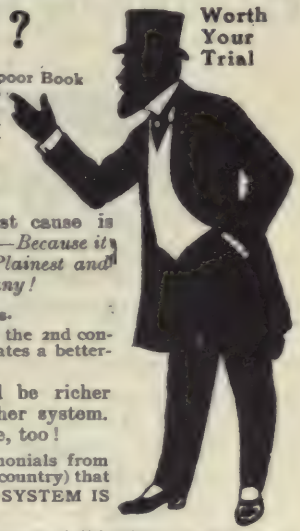

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tion of the individual, not only from a surgical but from a medical and a special view-point; and unless there is more co-operation and consultation work among the various representatives of the different departments of medicine, loose surgery is going to flourish. It is commonly understood that many a woman is operated on for pelvic troubles who has a minor pathological lesion, and who perhaps never knew that she was carrying organs that were not thoroughly normal, at least not until the surgeon made his investigation and decided that some repair of the cervix or the perineum was necessary to cure her of the multiplicity of complaints. Not infrequently these women are built on a wrong nervous plan, and their nervous mechanism is so unstable that they magnify minor symptoms more than they should, and when their complaints are emphasized by the surgeon, who is too often impatient to operate, they become firmly convinced that their whole organism can be benefited by a surgical operation. This deluded state lasts for a period of time, and in the unstable the time is usually very short, a few weeks or perhaps a few months, when all of the old nervous complaints return. They perhaps are seeking relief, and they reappear at the surgeon's office, only to be told that something else has gone wrong, that adhesions have unexpectedly developed, and that it will be necessary for them to undergo a second operation. This operation is done, and the end-results are practically the same. Not infrequently these unstable neurotics are operated on five, six, or even ten times, with the result that the same symptoms appear in due course after each operation.

Women who have grown old before their time are not infrequently subjected to needless and usually harmful operations, whereas an investigation of their arterial state, or their evolutional state, would clear up the situation and eliminate the necessity for operative measures. Then, too, as has been said before, surgeons are sometimes very busy, and make a rapid examination and follow it up with a rapid and not well-thought-out conclusion, only to find, to their chagrin, it is hoped, that the patient has something entirely different the matter with her. These cases are not uncommon, as every surgeon will admit. Even the best surgeons assert that it is often very difficult to make a completely satisfactory diagnosis. Women are operated on for fibroids when they have ovarian tumors, and are sometimes operated on for ovarian tumors when they are pregnant. The diagnosis is made only after the operation.

This is not said to censure the surgeon, but to suggest that

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in these times of stress and anxiety more consideration be given the individual under investigation and inspection, and that more historical data be gathered before a final conclusion is reached, and thus save many people from needless operations, which are frequently followed by needless and unnecessary symptoms.—*Therapeutic Gazette.*

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## TONSIL OPERATIONS

It is a healthful sign of progress that tonsil operations are no longer lightly undertaken, and that there is a keen understanding of the dangers that go with these operations. Tonsil operations are now justly given the same weight as major operations. According to some observers about one-third of the cases of suppuration of the lungs are directly traceable to tonsil operations; and this complication is by no means the only eventuality to be dreaded. But it is not to be wondered at that suppuration is common after removal of the tonsil when it is remembered that this operation must be undertaken in an open, septic field with no possibility for maintaining aseptic conditions. The operation of enucleation of the tonsil has helped to reduce the area of infection over the area produced by mere cutting through the tonsil as is done in tonsillotomy. Besides, but at best the operation is a bloody one. The hæmorrhage is too frequently left to itself, and only when it is marked and dangerous is there any attempt made to control it. There can be no provision made for catching the blood that flows from the field of operation, and it is allowed to run whither it will. In adults with hard, fibrous tonsils the blood vessels stay agape and the hæmorrhage is very likely to be more severe than in children. When general anæsthesia is employed there is very little ability to expel blood that enters the respiratory passages, and the blood with its load of organisms is very apt to find lodgment in the bronchi to set up suppurative processes. Moreover, the gaping blood vessels of the peritonsillar tissues encourage primary embolism of the veins. The emboli find their way directly through the right heart to the branches of the pulmonary arteries and their distributions. The same result may be achieved by phlebitis in the peritonsillar vessels and secondary embolism following the same lines as in primary embolism. Improved methods of anæsthesia and more refined technique of operation reduce much of the danger, but not nearly all, by any means. Although general anæsthesia adds to the dangers of tonsil opera-

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tions, nothing but general anæsthesia can be used in children or in adults of nervous disposition. Much of the aspiration effects following upon the hæmorrhage would be obviated by the use of local anæsthesia, but for the fact that because it is impossible to gauge accurately the amount of the anæsthetic absorbed, local anæsthesia is very treacherous in its action, and fatal outcomes are not uncommon with it.

On the whole the question of operating at all, the kind of operation, and the form of anæsthesia must be decided according to the individual variations, and no rule can be laid down to cover all cases. But in all cases the tonsil operations deserve a great deal more caution in their execution than is still accorded them. The danger is so real, and the outcome so uncertain that it has been recommended, at least for adults, that the tonsil be destroyed with the high frequency spark, at several sittings. In such cases there is little reaction, little inconvenience, and little danger. None of the dangers in tonsil operations should, however, prevent their execution where necessary. All surgical operations have an element of danger, but the danger will be reduced by a proper conception of the gravity of the operation, and will stimulate improvements therein.—*Medical Record.*

---

### On the Absorption of Drugs and Poisons Through the Vagina

In the *Journal of Pharmacology and Experimental Therapeutics,* Macht reaches these conclusions:

1. It has been shown that a large number of drugs and poisons—alkaloids, inorganic salts, esters, and antiseptics—can be and are absorbed through the vaginal wall.

2. Such absorption can be demonstrated experimentally by physiological and chemical means.

3. A review of the clinical and toxicological literature shows that poisoning through the vagina, of a grave character, is not very rare.

4. His experiments indicate, on the one hand, the possibility of administering drugs therapeutically for their constitutional effects, through the vaginal route; and on the other hand emphasize the great danger of the indiscriminate employment of various poisonous substances in the form of douches, tampons, "uterine wafers," etc.—*Therapeutic Gazette.*

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# Miscellaneous

### Prepare the Babies for Hot Weather

During the month of June it is not a bad plan for the physician to take mental "stock" of the babies under his care, especially such as are bottle-fed, with the general idea of recommending such treatment as will tone up and vitalize those whose nutrition may be below par, so that they may enter the trying summer months in the best possible condition to ward off or withstand the depressing influences of extreme heat or the prostrating effects of the diarrhœal disorders of the heated term.

Careful attention to feeding is, of course, a *sine qua non* and the details of the infant's nourishment should be carefully investigated and regulated. But this is not all. Many bottle-fed babies are below standard from a hæmatologic standpoint. The marasmic anæmic baby deserves special attention in the way of building up and restoring a circulating fluid which is deficient in red cells and hæmoglobin. In the entire Materia Medica there can be found no direct hæmatic quite as suitable for infants and young children as Pepto-Mangan (Gude). In addition to its distinctly pleasant taste, this hæmic tonic is entirely devoid of irritant properties and never disturbs the digestion of the most feeble infant. Being free from astringent action, it does not induce constipation. A few weeks' treatment with appropriate doses of Pepto-Mangan very frequently establishes sufficient resisting power to enable the baby to pass through the hot summer without serious trouble, gastro-intestinal or otherwise.

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### Dental Stigma of Syphilis

Syphilographers, such as Fournier, Gaucher, Sabouraud, and Hutchinson, have erected an extensive superstructure of dental dystrophies of hereditary syphilitic origin which include total and partial microdontism, anomalies of position, monstrosities, alterations of shape, alterations of mastication zone, spaced incisors, Carabelli's tubercle, etc. Roy, in a recent number of a dental journal (abstracted in *La Presse Médicale*, May 16), is antagonistic to the whole of this teaching. Not a

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single stigma, not even Hutchinson's teeth, he holds, is pathognomonic of hereditary syphilis. Any disease of the early period of childhood can provoke dystrophies of the teeth. Caries of the deciduous teeth is a powerful factor in retarding development and causing errors of implantation, because this affection influences the development of the jaws. Mouth breathing, however produced, likewise exerts a retarding influence on the development of the dental arches, and is thus a cause of malposition. Erosion of the free border of the incisors, causing the so-called notched teeth of Hutchinson, means simply, in Roy's opinion, that the infant suffered from some serious pathological state in the first three months of life. It could be syphilis, but it could also be measles or broncho-pneumonia. The notched incisors do not develop in the heredosyphilitic child unless there has been a period of grave infection corresponding to the first three months of existence. These dystrophies show absolutely no peculiarities in the syphilitic infant.—*Medical Record.*

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### Sexual Neurasthenia

Sexual neurasthenia is an impoverishment of nerve force, and without doubt prostatic disease in a large measure produces it. In this condition we may find a prolonged phosphaturia and oxaluria, which does not as a rule respond to a change in dietary or mineral acids. Therefore, in a neurosis, where there exists a continued phosphaturia or oxaluria, and a condition of irritation in the genital tract, after eliminating the possibility of calculus, one must remember the prostate as being the factor to receive attention. To diagnose such a neurosis therapeutically administer sanmetto in teaspoonful doses four times a day for a few weeks, and at the end of that time one may not only know the cause but also the remedy.

265


# The Canadian Practitioner and Review

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## Original Communications

### ONTARIO MEDICAL ASSOCIATION

By A. H. Wright, B.A., M.D.

In the summer of 1880 Dr. James E. Graham and I had a conversation in which one of us (I think he) suggested the advisability of establishing a Provincial Medical Association. We both set to work at once with this object in view. On October 7th Drs. Joseph Workman, C. W. Covernton, J. E. Graham, A. H. Wright, J. H. Burns and J. E. White met as an organizing committee in Dr. Graham's house. Dr. Covernton was elected Chairman, and Dr. White Secretary. Circular letters were sent to all local societies and many prominent physicians, asking for opinions respecting the proposed organization. The labors of the Secretary, Dr. White, for some months, were beyond praise.

All the local societies and individual physicians endorsed the scheme, with one exception. Sir James Grant, speaking for the Ottawa Medical Society, thought we should rather endeavor for a few years at least to throw all the life blood possible into the Dominion Association. These views, coming from one we respected so highly, were considered worthy of careful consideration; but so far as could be learned there was a unanimous opinion, outside of Ottawa, that the establishment of such a society would not injure the Canadian Association.

At a meeting held in Toronto, February 21, 1881, Drs. Macdonald, Mullen, Rosebrugh, Mackelcan and Woolverton, from Hamilton, met the Toronto committee, and the two were combined to form the provisional committee for organization.

The hearty co-operation of this strong combination from Hamilton gave much satisfaction to the Toronto men, and added greatly to the strength of the committee in the work of the organization. With deep regret I have to state that I am the sole survivor among the members of this original committee.

Since the first meeting in Toronto under the presidency of Dr. C. W. Covernton, there have been what I might call three crises in the history of the Association. The first arose from dissatisfaction regarding the work of the Secretary. It was generally recognized that his enthusiasm, energy and working ability contributed much towards the success of the Association in its earlier years. After a time it was thought that he was assuming too much, and attempting to "run the Association." Although it was generally conceded, even by his friends, that he displayed poor judgment, many disliked to see him humiliated, and urged him in a friendly way to resign. At a certain meeting he was dismissed in rather a cruel way by a vote which was almost unanimous.

At the same meeting several changes were made in the constitution, one of which I always thought unfortunate. According to the original constitution the important committee on nominations was formed as follows: At the first meeting nine members were elected. I am not sure as to the exact number, but let us suppose it was nine. Each succeeding year three were dropped, and three were elected. This plan is the best I have known, and prevents largely the dangers which are apt to occur in any society through the work of small coteries at certain times.

The second crisis occurred shortly after the affiliation of the Ontario with the Canadian Medical Association. It unfortunately happened that a clause was introduced which afterwards created considerable trouble and dissatisfaction. According to it no provincial association could hold its meeting during the year when the Canadian Medical met in that Province. The first trouble in connection therewith arose in 1910, when the Canadian Medical met in Toronto.

The Ontario Medical, under the presidency of Dr. Casgrain, having no knowledge of this objectionable clause, made all arrangements to hold its meeting that year at Niagara Falls. When the clause was pointed out to them, the president and local committee at Niagara Falls refused to give up their meeting. As president of the Canadian for that year, I made strong efforts to induce them to change their decision, and postpone the meeting for one year. This was done with happy re-

sults. Two very successful meetings were held, one in Toronto in 1910 and the other in Niagara Falls in 1911. When the Provincial Association was prevented a second time from holding a meeting in 1913, there was a very strong feeling of resentment among the members. It was felt that the arrangement was materially injuring the Provincial Association, without helping in any degree the Dominion Society. I had hoped that something would be done in 1911 or 1912 to remove the grievance, but as nothing had been done, I gave notice of motion to have the Ontario withdraw its affiliation from the Canadian Association. At the meeting in London many members of the Dominion Association expressed strong disapproval, and wished me to withdraw the notice of motion. I positively refused, but, at the same time, stated that I did not object to the affiliation in itself, but I did object to interference with our rights in Ontario to hold our meetings when we pleased. To avoid any mistake I put it in writing, intending to send it to the Ontario Secretary, but instead of accepting my proposal in a friendly spirit, many of them continued their protest, while a few became actually offensive.

I felt very sorry to be misunderstood, especially by members of an Association which had honored me by making me President, but I felt certain that I was right, and they were wrong; and if the worst came to the worst, I was determined to stand by the Ontario Medical Association, because I loved it more than any other organization I was ever connected with.

I received a letter from Dr. Murray MacLaren, President-elect of the Canadian Association, in April, 1914, asking me to explain the situation. I replied: "I do not think that many (if any) want permanent separation, but rather a different sort of affiliation. The present arrangement is complex and unsatisfactory. The Ontario members, so far as I understand their opinion, would like to have absolute control of their provincial society. I have little idea as to what will be done at the next Ontario meeting, but I have every reason to hope that a friendly feeling will be shown towards the Dominion Association."

I found before the Ontario Medical meeting that many members of the Canadian were quite inclined to agree with me. *The Canadian Medical Association Journal* published an editorial in April, 1914, in which the writer referred to the fact "that each Provincial Association agreed to forego the right of meeting in the year in which the larger Association met in the province." After stating that this made no sacrifice for Quebec and the smaller provinces, he said "Ontario stands in

a different category. . . . and the suspension of a meeting is all the more hardly felt. . . . At the meeting in July the abrogation of this rule might well be made a matter for consideration."

On the day preceding the meeting I was amazed to see certain remarkable statements appearing with flaming headlines in one of the daily newspapers of Toronto. The headlines in large letters were: "Doctors' Meeting May be Stormy," "Local Clique Said to be Working for Split in Associations," "Ontario Medical Meeting Promises to be the Liveliest on Record." Under these headlines were several remarkable statements, including the following: "They, the clique, hope to bring about a break between the Associations, and whether they succeed remains to be seen. If the meetings were held outside of Toronto, an attempt to punish Dr. Macphail would be defeated by a large majority, but to-morrow's meeting may be packed with sympathizers of the clique. If they succeed, the outside members, with a large and influential section of the Toronto profession, will in all probability form a new Ontario Association in affiliation with the Canadian. . . . The anti-Macphail crowd are interested in four medical journals, whose existence is threatened by the journal edited by Dr. Macphail. They hope that the break between the two medical journals will cripple Dr. Macphail's journal, and help their own. They are, however, not far-sighted. This was shown when they blackballed Dr. Macallum in the Academy of Medicine."

These statements were interesting to me, inasmuch as I was "the clique" so far as this meeting was concerned. Beyond some general explanations, such as those given to Dr. MacLaren, I said absolutely nothing to anyone expecting to attend that meeting until after the proceedings commenced. From the day that the Ontario Executive threatened to repudiate affiliation because "they said the majority of the members knew nothing about the law regarding the affiliation, which had been rushed through at a small business session in the last few moments of the Hamilton meeting in 1908, the majority, even of the small number present, not knowing what they were voting for," I had been feeling Ontario's pulse, and I knew in giving my notice of motion that I was acting in accordance with the wishes of the vast majority of our members, especially outside of Toronto. As to the results at the meeting I never had doubts. According to an understanding between Dr. Wallace, of Hamilton, and myself, during the progress of the meeting, he moved, seconded by Dr. N. A. Powell, that the matter be

left to a certain committee. I withdrew my motion and supported Dr. Wallace, whose resolution passed without a division.

I may say incidentally that there is no such thing as "an anti-Macphail crowd" in Toronto. I do not believe Sir Andrew has a single enemy in the city. Personally, I look upon Andrew Macphail as one of my dearest friends, and the flavor of our friendship is very sweet to me.

And now let us consider the present crisis, which is very serious. One of the aims of this historical sketch is to show how deep is our indebtedness to the profession of Hamilton. In the organization of our Association many of us felt that we got more assistance in Hamilton than in Toronto. In that connection I have always felt that the late Dr. Mullen, who was a man with very high ideals, was a great tower of strength.

While preparing for this year's meeting it soon became evident that the local committee in Hamilton intended to take full control. Our officers in Toronto were slighted. The Secretary, Dr. Clarkson, was treated with scant courtesy, and practically ignored. I fear that the Treasurer, Dr. Elliott, was also treated without much ceremony. No local committee has the right to assume such an arrogant attitude. Serious trouble arose in the three health associations, the officers of which refused to give up the control of their scientific programmes. Friction became so pronounced that it looked at one time as if a break would occur, and these societies would withdraw and hold their meetings elsewhere. This would have meant a loss for the Hamilton meeting of 300 to 400 visitors. Fortunately the matter was arranged. The three health associations preserved their identity and held three meetings on three consecutive days, at the same time doing a certain amount of "joint work." In this connection one might ask why did not Dr. Clarkson also assert his rights. I do not know the answer, but he is not naturally aggressive; and, anyway, he could do but little, as the President supported his local committee. It seems ungracious to criticize the President, who by his conduct and ability as a presiding officer, won golden opinions during the meeting. But he and the other members of the committee must accept their share of responsibility for the foolish actions of the local secretary, as they apparently gave him a free hand, and, as far as outsiders can judge, supported him in every way. So far as the programme of the Ontario and Canadian Associations was concerned, it is doubtful if anyone outside of Hamilton approved of bringing so many outsiders—33 or 34 from the United States and only 13 or 14

from Canada. After all, these Associations are Canadian, and physicians from Canada should read the majority of the papers. No medical association in the United States would think of asking Canadian physicians to read over 70 per cent. of the papers at any meeting. However, very few made any complaints, but many expressed the hope that such a thing would never happen again. The three health associations remained essentially Canadian, and their meetings were not less successful than the others.

One person who knows a good deal about the matter expressed the opinion that nothing unconstitutional had been done. I do not wish now to discuss the legal aspects, but I think Drs. Morton, Parry and Mullen exceeded their rights when they took control of everything. Three of the five societies held a similar opinion and refused to consent. What the C.M.A. officials thought I do not know. However, apart from any consideration of the rights of the Dominion Association, it was bad policy for the Provincial body to antagonize three strong associations devoted to the interests of public health.

And now a few words as to publication, which I am writing on my own responsibility, and without the knowledge of any other member of the Association. If, therefore, there be any odium attached to the opinions expressed, I must accept it all. The publication of the transactions in book form is, of course, not a new idea. It was often talked of in earlier years, and once tried with rather a dismal result. The custom universally observed heretofore in the O.M.A. has been to divide the papers and addresses among the Ontario medical journals for publication. There are now five medical journals published in Ontario, and Drs. Morton, Parry and Mullen ignored four journals, and appointed the publishers of one journal, the Macmillan Company, "Official Reporters of the Convention."

I understand the Macmillans have agreed to publish the papers in a volume of over 300 pages, taking all the risks themselves. This looks generous, but very peculiar, because an experienced business firm understands quite well all the risks involved. "A volume of transactions" has little commercial value, and the sale of such a publication is not likely to cover expenses. A solid, level-headed firm such as the Macmillans would scarcely take a risk of that kind without the prospect of compensation in some other direction. The air is full of rumors, which under ordinary circumstances one might assume to be incorrect; but unfortunately rumors which floated months ago

about the doings of the energetic trio in Hamilton seemed to be absurd, but were actually true.

Let me ask this trio when will the different associations get a report as to members, finances, and other details? I was informed more than two months after the meeting that no such report had been presented. Unfortunately, the local committee did collar the management of the financial details of all the societies of the meeting. How long will the committee remain in existence? Who is Dr. Routley, the new Secretary? Is it true that he was part of the *bargain*, and the nominee of Macmillans? Why were the former Secretary and Treasurer frozen out? Is it true that a scheme has been concocted whereby an association journal will be published with the trio in charge of the editorial department? I feel sorry and reluctant to ask if these men have taken advantage of their positions as temporary officers to do something which will benefit themselves, and give them practically the control of the Association. Two of them are personal friends of long standing. In their student days they always received a warm welcome in my house. Since then they have ever been held in the highest regard by my family, including myself. When I hear such charges made against them, I should like much to be able to say: No, these two—boys yesterday, men to-day—are clean and straight.

In conclusion, let me make my position clear. If certain members want an association journal, such an idea is perfectly legitimate and unobjectionable; but let there be no backdoor scheming. Let those in favor express their opinion, formulate their plan, give due notice of motion at one meeting, and let members vote on it at the next, and let every loyal member accept the mandate of the majority.

## A PLEA AND A PLAN

Presidential Address, Canadian Public Health Association, May, 1918.

W. H. Hattie, M.D., Halifax, C.O.H., Nova Scotia.

The creation of a really widespread interest in the health of our people remains an unrealized dream of the sanitarian. Our prodigality in respect to the greatness of our assets—a vigorous, resourceful and efficient manhood and womanhood—is a matter which should always have given us much concern, and which in the present crisis must receive most careful consideration if we may reasonably hope to escape ultimate disaster. Out of all the miseries of the war, there is developing an appreciation of the value of man power; but even to-day there are but few people who fully realize how essential good health is to the material and moral welfare of both individual and nation.

Our main thought in these tense days is for the Empire. The peril of to-day is so menacing that all who prize the freedom and the justice which British rule assures are sobered in contemplation of the consequences of a possible defeat. Patriotic fervor comes easy at such a time. But it is not only in time of war that the integrity of the Empire is threatened. We will win this war if we are not too cocksure; but unless our people have the alertness and the energy and the acumen to at least keep pace with other peoples in the competition for industrial and commercial supremacy, we need expect nothing else than a retrogression which will ultimately result in the dissolution of the Empire. In the legitimate attempt at peaceful conquest, the battle will unquestionably go to the strong. And so, for the sake of the Empire, as well as for the sake of each individual of which the Empire is composed, every effort should be put forth to limit sickness and suffering and death, to conserve health and virility, and thus to assure productiveness and prosperity.

According to the by-laws of this organization: "The objects of the Association shall be the development and diffusion of the knowledge of sanitation in all its branches, and all other matters and things appertaining thereto or connected there-

with." We could scarcely ask for a broader or more comprehensive commission. We are a national organization. As such we are in an exceptionally favored position for influencing the thought and activities of the whole Canadian people. I feel strongly that an educational campaign initiated and maintained by this Association would result more satisfactorily than any similar effort originated by individuals or by provincial or local organizations. Such a campaign would be in fulfilment of that part of our commission which relates to the "diffusion of the knowledge of sanitation," and it is so conspicuously necessary that one feels that it does not require a special plea.

The "development of the knowledge of sanitation" is also so apparent a need that argument in its behalf is surely not requisite. It might, however, be well to say that we must now apply the word "sanitation" in a very liberal way, and construe it to include everything which bears in any particular upon the public health. This brings into consideration not merely matters relating to the sufficient supply of pure air and water and food, the removal of refuse, the control of communicable diseases, and kindred matters which have always engaged the attention of sanitarians, but also the various factors which associates with feeblemindedness, insanity, the neurotic diathesis, criminality, and in fact the whole wide range of eugenics. Moreover, attention must be given to child nurture and culture, to the native and alien poor, to the immigrant, and to the soldier whose military experience has brought about any incapacity. And then the problems of industrial hygiene, of housing and of town-planning, must not be neglected.

As to the plan, this does not appear in the by-laws so I lack the guidance which has thus far proved so helpful. One, however, does not need to be a prophet or the descendant of one in order to foresee that money—and lots of it—will be required to carry out such a programme as is laid down for us. We must have a salaried organization and we must have the funds to meet other expenses. As a first step, I have to suggest an effort to greatly enlarge our membership which is at present quite too small. And in order to make our meetings attractive to those who would be confused by papers or discussions of a technical description it appears to me desirable that such disquisitions should be limited to the special sections, so that the general sessions may be devoted to the many practical problems which can be presented in terms which are comprehensible to everyone.

I fear that we are as a people rather too ready to fall upon the Government for support and even for direction, and we have undoubtedly suffered much because of our disposition to wait in hopeful expectation of Government action in matters which we might very well have undertaken and executed ourselves. But in a matter which so intimately affects every citizen of the Dominion as the public health, there would seem to be exceptional justification for approaching our Federal authorities with the assurance that a request for a substantial subsidy to our Association could not well be refused. From this source we might expect at least a sufficient amount to provide an honorarium for our secretary which would in part recompense him for the time and attention he would wish to give to the direction of the Association's affairs, to pay the staff which he would keep employed, and to cover the ordinary office expenses and the cost of educational propaganda.

Thus strengthened and supported, the Association would be in a position to accomplish an inestimable amount of good, and to go far towards attaining the objective of our organization.

It is a great satisfaction to know that a section on Child Welfare has been inaugurated under such auspicious circumstances, and that we may expect the formation of sections in Mental Hygiene and Social Hygiene.

A recent statement made in our Federal Parliament to the effect that thirty per cent. of the young men who reported under the Military Service Act were found physically unfit for active service should incite everyone who has the interests of Canada at heart to put forth every effort to remedy so deplorable a condition. "Where there is no vision the people perish." Because of our lack of vision, we are losing from preventable diseases many more Canadian lives than are being lost to us in the field of battle. The only logical offset to the loss of life at the front is the conservation of life at home. The only possible way to restore our material losses in war is to increase our production at home. Can this be done by a manhood, thirty per cent. of which is more or less physically unfit? We all anticipate a post-bellum condition which will be characterized by a much fiercer competition in the commercial relationships of the nations than has as yet been experienced. Should, as is so generally expected, a period of compulsory military training be hereafter required of our young men, we will have a further factor to cope with which will accentuate the need for fullest efficiency. If we are to maintain our place amongst nations—and unless we do, all the sacrifices we have made to the war

Moloch will have been made in vain—we must bring our manhood to a much higher status of physical vigor than that which we now claim. We must not only lessen our demands upon the ferryman of the Styx, but we must greatly increase our devotion to Hygeia. Of all the problems which confront us to-day, none is of greater moment either in the prosecution of war or in the preparation for peace, than the saving of human life and the elimination of conditions which are unfavorable to the fullest attainment of that physical vigor which is prerequisite to the mental acumen and moral sturdiness upon which real efficiency depend.

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**At What Age Should Infants be Vaccinated?**

It is generally claimed that the new-born are not susceptible to vaccination; therefore, an official circular, dated August 7, 1903, ordered that children should not be vaccinated before the age of three months. The application of this measure has proved very inconvenient. In the maternities, the women recently delivered stay in the institution only a few days after their delivery, and the newborn are thus taken away from these services without having been vaccinated. This renders it difficult to enforce the law. The obstetricians of the hospitals, notably Professor Pinard, have deliberately disregarded the law, and have been vaccinating all infants born in their service during the first few days of life. This practice has yielded results completely at variance with previous beliefs; it makes it possible to protect all the little ones against variola. It is all the more urgent at this time because they can contract the disease precociously. As proof of this statement may be cited the recent case of a Paris child, two months of age, which was not vaccinated, and which succumbed to smallpox. Therefore, Professor Wurtz, chief of the Vaccine Institute, suggests that all children be vaccinated for the first time between the ages of ten days and three months.—*Lyon Medical.*

# Editorials

## THE TREATMENT OF THE BLIND

There are about 700 blind persons in Canada, of whom over two-thirds lost their sight after the age of 21. In the five schools for the blind in Canada there are over 306 pupils. The pupils after leaving these schools are generally in poor circumstances, because the proper means have not been provided to afford them remunerative work.

At the present time there are about 80 blinded Canadian soldiers. We are glad to report that the Canadian National Institute for the Blind has been incorporated for the purpose of helping the blind by the establishment of industrial training, with workshops and other necessary offices. One Industrial Training School will be opened in Toronto in September. The governing body will consist of eighteen members, of whom at least one-third must be blind. The blind members are Capt. E. A. Baker, Toronto; Harris Turner, M.P.P., Saskatoon; A. G. Victs, Toronto—who lost their sight in the war; Rev. A. T. Barnard, Edmonton; C. W. Carruthers, Toronto; Dr. C. R. Dickson, Toronto; Dr. Thomas Milroy, Winnipeg, and S. C. Swift, Toronto. The last five have been blind for many years, and have a wide knowledge from practical experience of the problems to be confronted. It is believed that $100,000 will be required for the first year's work and $70,000 for the second. It is hoped that both Provincial and Dominion Governments will assist, and an appeal for subscriptions will be made to private citizens.

## HOSPITAL IN FRANCE

Hon. N. W. Rowell, in his address recently delivered to his constituents of West Durham, made reference to certain Canadian hospitals he had visited in France. He spoke especially of that at Doullens, Col. (Dr.) Reason being O.C. During the German drive of March 21st, many casualty clearing stations and hospital units were compelled to evacuate and retire. In this hospital, with 600 beds, 42,000 patients had been admitted and evacuated between March 21st and July 1st. While they were caring for the wounded men the German bombs destroyed the operating room, cruelly murdering the nursing sisters and doctors. "As I stood beside the graves of those nursing sisters and doctors, who had been murdered while engaged in the Christlike ministry of trying to succor the wounded and the dying, I determined that as long as a nation glories in such barbarity, I believe it will be my duty, both to the men who lie buried, and those in the fighting line, to see that adequate reinforcements are provided to enable them to carry on their work."

## TORONTO GENERAL HOSPITAL

The Superintendent of the Hospital, Horace L. Brittain, contemplates the adoption of a new plan, with the proper collection of records, especially in the departments of surgery and pathology. The intention is to have a proper supply of typewriters and stenographers. The stenographers will be available for both the operating room and the pathology department, and arrangements will be made whereby

the surgeon's report will be taken, and also that of the pathologist. A messenger will take the specimens from the operating room to the pathology department. These specimens will not be wrapped in pieces of gauze as formerly, but will be placed in envelopes or boxes of various sizes, lined with wax paraffin. These envelopes or boxes will be properly labelled. When the pathologist receives a specimen from the operating room he will review the report of the surgeons, and after making his examinations will dictate his findings to the stenographer. These reports will be made out in triplicate, both as to the operating room and the pathological laboratory. One report will be sent to the physician or surgeon in charge of the case, the second will be attached to the patient's chart, and the third will remain in the pathology department, and will be properly filed.

## THE PRESIDENT OF THE ONTARIO MEDICAL ASSOCIATION

We are glad to say the election of Dr. Geo. S. Cameron, of Peterborough, to the Presidency of the Ontario Medical Association is universally approved throughout the Province. This brings to our mind that singularly happy meeting in Peterborough in 1915. Dr. Cameron happens to be one of the best of an exceptionally splendid bunch of really good Fellows, who, with the assistance of the majority of the good citizens of that town, entertained the visitors in a whole-hearted, generous manner. That was the second meeting held in one of the "smaller centres." The first of these was held at Niagara Falls, under the Presidency of Dr. Casgrain. We are in-

clined to bracket these two meetings, because they were alike in many respects. Both were very interesting and exceedingly pleasant.

In 1915 Peterborough had only twenty-two doctors, and of these three, namely, Drs. Young, Frederick and McPherson, were away at the Front.

We understood at the time that the work of preparation was done by eighteen men; what they accomplished was wonderful, beyond description.

In offering our congratulations to Dr. Cameron, we desire to express the wish that he may receive loyal support from all the members in all parts of Ontario.

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## EDITORIAL NOTE

### The Institute of Public Health, London

We are very pleased to learn that the Institute of Public Health of London is doing admirable work. It was organized under the Board of Governors of the Western University in 1912, in a building which had been erected by the Provincial Government, and was opened for work early in 1913.

In addition to its association with the University, it has close relationships with the Local Board of Health, the Provincial Board of Health, and with the municipalities of a good portion of Western Ontario.

Among those in charge are: the Professor of Public Health in the University (ex-officio), the Chief Pathologist of Victoria Hospital, the Chief of the Department of Chemistry, and other members of the Western University staff and Victoria Hospital staff.

The Institute is under the immediate control of a committee of the Board of Governors, composed of the Mayor, the Chairman, Mr. Arthur White, and Drs. H. A. McCallum and W. Waugh.

# News Items

A new hospital, to be known as the Rathbun Military Hospital, was opened at Deseronto, August 12th.

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The next meeting of the American Public Health Association will be held in Chicago, October 14th to 17th, under the Presidency of Dr. Charles J. Hastings, Toronto.

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The Ontario Health Officers' Association: Dr. G. R. Cruickshank, Windsor, President; Drs. W. A. McCauley and Dr. Dickinson, Vice-Presidents; Dr. J. W. S. McCullough, Secretary.

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There is at present rather a serious epidemic of typhoid fever in Chatham, Ontario. Energetic steps were taken, August 19th, to stop the epidemic by the Council and Local Board of Health.

We regret to say that Dr. T. L. McRitchie, M.O.H., who was indefatigable in his efforts to discover the source of infection, and also in his general supervision of treatment, became ill immediately after the meeting on the 19th. In fact, we are told that he left the meeting to go to bed, and soon developed symptoms of typhoid.

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Lt.-Col. (Dr.) H. R. Casgrain, who has been for some time acting as O.C. at No. 8 Canadian Hospital, St. Cloud, France, has been awarded the Cross of the Legion of Honor by the French Government for his devotion to and care of French soldiers. Col. Casgrain went overseas in 1915, and was seriously ill for a time at Lemnos in the Ægean Sea. After recovering at the City of Alexandria, he returned to England, and was for some time O.C. at Bushy Park Hospital, Hampton Court. Several months ago he was transferred to France, and placed in command of St. Cloud. He went from France to England, August 1st, on two months' leave. His many friends feel that he has "made good," and now well deserves a holiday.

The report comes from St. Thomas that new additions are required for the Amasa Wood Hospital in that city. It is stated that the most serious need is for better quarters for the nurses.

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At the recent meeting in Hamilton the following officers were elected for the Canadian Public Health Association: President, J. A. Hutchinson, Westmount, Que.; Vice-Pres., Dr. H. W. Hill, Mrs. L. A. Hamilton, and Dr. R. M. Bole; Secretary, Dr. R. D. Defries, acting for Major (Dr.) J. S. Fitzgerald, who is overseas; Treasurer, Dr. George Porter.

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### The Adrenalin Determination of Cardiac Resistance

Loeper, Wagner and Dubois-Roquebert, in *Le Progrès Médical*, allude to the great frequency of tachycardia and cardiac erethism early in the war, which led to many tests of cardiac function. While nothing new has come to light, old tests have been systematized. A source of confusion is the part played by cardiac and systemic effort, for with general failure of forces the heart, too, must suffer. The simple way of testing the heart is by increasing peripheral resistance, and to secure the latter one may compress the large peripheral arteries, or place the subject under the influence of adrenalin. The latter drug is known to raise the blood pressure by 2 cm. of mercury through vasoconstriction. In this test it should be possible to control the heart's shadow for the presence of dilatation. The dose is 1 mgm. and the interval one hour, or better, there should be a series of half-hour exposures, with one hour as optimum. One hundred subjects were examined, the authors beginning with simple and passing to the more complicated cases. In the first types the cardiac areas showed no change for at least an hour, but later in a few cases the heart appeared to have undergone slight contraction. But in the true cardiac subject, with valvular lesion or hyposystolia, the shadow at once augmented, as a rule completely. Hence the two extremes were well differentiated, for the tachycardiac and erethetic heart was shown to be sound and at the other extreme far from sound. The two extremes comprised nearly all the cases, for of 50 subjects 21 showed no augmentation and 23 marked dilatation (17 of the entire heart). This leaves but six intermediate cases in which there was a slight contraction. The authors hold that there should therefore be no trouble in distinguishing between the two types in practice.—*Medical Record.*

# Personals

Dr. E. Ogden, of Toronto, has removed to 9 Spadina Road.

Surg.-Gen. (Dr.) G. Sterling Ryerson after leaving Seattle, Washington, went to Alaska, and returned to Toronto, August 30th.

Capt. (Dr.) Morley Gorman, Postville, Ont., has been awarded the Military Cross.

Lt.-Col. (Dr.) C. F. Martin, of Montreal, has gone to France as O.C. of one of the Canadian hospitals.

Dr. James C. Watt has been appointed Associate Professor in Anatomy in the University of Toronto.

Major (Dr.) J. G. Fitzgerald, of Toronto, has gone from England to France, where he is acting as pathologist.

Dr. L. DeLatbiniere Harwood, of Montreal, has been elected Dean of the Medical Faculty of Laval University, to succeed the late Dr. E. P. Lachapelle.

Dr. H. B. Anderson, of Toronto, was elected Vice-President of the American Therapeutic Society at the annual meeting held in Richmond, Va.

Lieut.-Col. (Dr.) Walter McKeown, Toronto, has been promoted to the rank of Colonel, and is now O.C., Richville Hospital, Brighton, England.

Capt. (Dr.) Thos. Morrison, Hamilton, returned from overseas, and has been appointed Assistant Director of Medical Services at Niagara Camp.

We have to announce with deep regret that Dr. H. W. Hill, Professor of Public Health in the Western University, Director of the Institute of Public Health and M.O.H., London, has returned to Minnesota.

Lieut. Wm. E. Lepper, eldest son of Dr. W. J. Lepper, 121 St. Clair Avenue West, Toronto, was reported wounded on August 15th. Two brothers, Lieuts. Jim and Basil Lepper, have been in France since 1915.

Dr. E. Fraser Bowie, of Toronto, has been appointed Medical Examiner for the Society of A.O.U.W., in the place of Dr. J. Milton Cotton, deceased.

Major (Dr.) Ernest Young, who recently returned from France, left Kingston, August 9th, to commence his duties as O.C. at the Ontario Military Hospital, Cobourg.

Dr. Duncan A. Carmichael, Oshawa, formerly Superintendent of the Calydon Sanatorium, Gravenhurst, has gone to New Brunswick, where he is acting as Superintendent of the Jordan Memorial Sanatorium, succeeding Dr. David Townsend.

Dr. William Goldie, of Toronto, has gone overseas. He commenced his course of training at the depot in England in the latter part of July. As that course takes about one month, he expected to be ready for hospital work about the last of August.

Hon. Dr. W. C. Roche, after living in Minnedosa, Manitoba, for more than thirty years, is making arrangements to remove to Ottawa as his permanent home. This move was induced by his appointment to the position of Chairman of the Civil Service Commission, Ottawa.

Hon. Dr. H. S. Beland, who has returned from captivity in Germany, reached New York, August 4th, and received a warm welcome from his friends in the Province of Quebec, August 6th. It will be remembered that Dr. Beland was elected by acclamation as the representative of Beauce constituency, Quebec, at the last election.

After Dr. Parsons left England, Dr. Duncan Graham was made head of Medicine at the University Hospital, Basingstoke, and according to the last reports was doing exceptionally well. The following are recent additions to the Basingstoke Hospital: Drs. Wishart, who was in the R.A.M.C. (for three years), Eric Clark, Scott and Roscoe Graham.

Captain (Dr.) John Nelson Humphrey, R.A.M.C., of Tara, Ont., has been awarded the Military Cross. He graduated from the Toronto University in 1914, and was for a time house surgeon in the Toronto General, and also at the Wellesley Hospital, Toronto. He went overseas three years ago last April, and has seen service in Saloniki, Malta, Egypt, Port Said, France and Italy.

# Obituary

### G. F. SLACK, M.D.

Dr. Slack, a well-known physician of the Eastern Townships, died June 5th at Farnham.

### W. E. BROWN, M.D., C.A.M.C.

Dr. W. E. Brown, of Gananoque Junction, Ontario, was killed in France early in July, aged 24. He was a graduate of Queen's University, Kingston.

### W. G. HUTT, M.B.

Dr. W. G. Hutt, a well-known physician of Newmarket, Ont., died suddenly at his home, August 18th, aged 51. Soon after graduating from the University of Toronto in 1891 he commenced practice in Newmarket, and continued his work in that town up to the last day of his life.

### E. J. LEARY, M.B.

Dr. E. J. Leary (Tor., '17) was drowned in Meat Bird Lake, near Sudbury, August 7th, aged 28. After service overseas he returned to Toronto, and at the time of his death he was a member of the medical staff of the Canadian Copper Company.

## LIEUT. A. MURRAY CLARE, M.D.

Dr. Murray Clare was killed in action June 15th. He was a student in medicine in Winnipeg University when the war broke out. He went overseas in 1915 as a private. The following year he returned to Canada and resumed his medical course. After receiving his degree he returned to England, and was first in the C.A.M.C. and then in the R.A.M.C., and finally became M.O. of the Durham Light Infantry.

## J. MILTON COTTON, M.D., M.R.C.S., ENG.

We have to announce with deep regret that Dr. J. M. Cotton died suddenly at his home, 20 Bloor Street East, Toronto, August 11th, aged 58. He graduated M.B., Toronto, and M.D., Victoria, in 1880. After practising for a time at Burnhamthorpe he took a post-graduate course in London and Edinburgh, and became M.R.C.S., England, in 1883.

He had ability and a happy manner and was much liked by his patients and intimate friends.

After removing to Toronto he devoted himself especially to surgery, and for 15 years was the senior surgeon at Grace Hospital, Toronto. He was also a Fellow of the American College of Surgeons. His wife died after a lingering illness about six months ago. Of the three children who survive, two boys are in khaki, one overseas, and the other on duty in Toronto.

## JNO. T. GILMOUR, M.D.

Without any warning, Dr. J. T. Gilmour's friends heard, July 29th, that he had died suddenly on that morning. Apparently in his usual health, he was walking in his garden after breakfast. He suddenly fell over, and those who picked him up found that he was dead. He graduated M.D. from Trinity University in 1878. After graduating he commenced practice at Toronto Junction and soon acquired great popularity. He took an active interest in politics, and sat in the local legislature as the representative of West York from 1886 to 1894. He also took an active interest in educational matters, and was chairman of the High School Board at the Junction for some years.

In 1896, he was appointed Warden of the Central Prison. While at work there he proved himself an excellent administrator, and also did much in the direction of prison reform. As a consequence, when the Ontario Reformatory was completed in 1913, Dr. Gilmour was selected to take charge of it. In 1916, he was appointed Parole Commissioner for Ontario.

Sir William Hearst, the Premier of Ontario, spoke of him as follows: " He was a man for whom I had the highest regard, and I feel that the province has sustained a serious loss in his death."

Lieut.-Col. (Dr.) Charles H. Gilmour, who has been in khaki since the commencement of the war, and was head of the surgical department at Orpington Hospital for some time, and now on duty in Toronto, is a son.

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Mrs. MacNabb, widow of the late Dr. MacNabb, of Dupont Street, Toronto, was found dead in bed on the morning of August 7th, the cause of death being asphyxiation from poisonous gas.

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We have to announce with deep regret the death of Major Sidney Smith Burnham, D.S.O., eldest son of Dr. G. H. Burnham, of Toronto, who was killed during the allied advance of August 8th. He went overseas as a lieutenant in May, 1915; was promoted to the rank of Captain in France in August, 1916. Early in 1917 he was made a Major, and received the D.S.O. for outstanding valor at the Battle of Hill 50, October, 1917.

His younger and only brother, Major W. H. Burnham, C.A.M.C., who has been overseas for two years, was decorated by the Italian Government for bravery. He is now O.C. at Westcliffe Hospital, Folkestone, England. A sister, Miss Mary V. Burnham, has been working for the past two years in the Canadian Officers' Convalescent Home, France.

## AN APPRECIATION OF DR. J. T. GILMOUR

JOHN HUNTER, M.B., TORONTO.

In the County of Durham, some fifteen miles, or so, north of Port Hope, in one of nature's amphitheatres, surrounded by hills, north, east, and south, nestles Millbrook—one of our many beautiful Ontario villages.

It was the writer's fate, in May, 1875, to have to change the name Hamilton for that of his own on a very modest little sign-board hanging over the door of an office on one of the streets of this pretty village.

In much smaller villages—if even they could all claim to be such—about equally distant—east, south, and west, three young physicians were ambitiously, and industriously seeking professional, and pecuniary success. These were the late Dr. King of Peterboro', the late Dr. Corbett of Port Hope, and the late Dr. Brereton, ex-M.P.P., of Bethany. In the later "seventies or early eighties" the late Dr. J. T. Gilmour joined us, and began to practice a few miles from Millbrook.

These four young men had a great deal "in common." All were above average in stature, and had well "set-up" figures. They were fine-looking men, dressed well, and each had a refined, and very attractive personality. It can be very truly said of them, that they had "conscience, character, and culture." They all seemed very conscious of their obligations, and of their opportunities, and they sought to faithfully discharge the former, and to make the best possible use of the latter, and therefore as physicians, and as citizens, they served their communities splendidly. Their character embraced the Christian and manly virtues, and stood above all reproach. During several years they invaded each other's fields, and there was the most complete absence of all professional jealousies, or bickering. Their culture embraced the best in the science and art of medicine of their day. They were "scholarly men" in other fields of learning.

A great change has come over medical men within the past three or four decades. Thirty, or forty years ago, leaders in medicine were often leaders in politics, *e.g.* Sir Charles Tupper and Sir James Grant. Many of our finest platform speakers were physicians. To-day our medical leaders take about as

much interest in party politics as they do in Sanscrit, and they have no standing in "platform oratory." Dr. Gilmour early evinced a keen interest in party strategy, and in party warfare. He represented West York for several years in the local legislature. His life work, however, really began when he was appointed Warden of the Central Prison. He was eminently fitted for the position. His medical training enabled him to determine—more or less accurately—the importance of the factors that enter into the production of a criminal—the morbid, physical, psychic, social and moral conditions. His political experience helped in framing measures pertaining to criminology. His commanding personality made a look from him far more impressive than many threats from a "lesser man." His big-hearted humanity made the criminal feel that "it was worth while to be good," if only to please the Warden. He never "played the role" of the petty tyrant, but always appealed to the best in the criminal in the hope of inspiring him to become a better man. He greatly helped in the reform of prison management, and in placing it on a more scientific and natural basis. Prison life in Ontario to-day gives the criminal a real opportunity to become a better, and even a useful, citizen, instead of coming out more helpless, and more vicious, as he often did, on account of his treatment and his associations.

Dr. Gilmour, in addition to his special work, was a very industrious citizen. He took a keen interest in church work and in many matters pertaining to civic life. His unexpected and very sudden death came as a great shock to his family and to a very large circle of friends.

# Book Reviews

*Progressive Medicine*—a quarterly digest of advances, discoveries and improvements in the medical and surgical sciences. Edited by HOBART AMORY HARE, M.D., Professor of Therapeutics, Materia Medica and Diagnosis, in the Jefferson Medical College, Philadelphia; assisted by LEIGHTON F. APPLEMAN, M.D., Instructor in Therapeutics, Jefferson Medical College, Philadelphia. Volume II, June, 1918. Philadelphia and New York: Lea & Febiger, 1918.

The contents of this volume are: Hernia, Abdominal Surgery, Gynæcology, Disorders of Nutrition and Metabolism, Diseases of the Glands of Internal Secretion, of the Blood and Spleen, and Ophthalmology. Clark gives an excellent review of the work done with radium, which all observers consider has come to occupy a high place in the treatment of cancer, fibroids, leukæmia, etc. The whole of this volume is on a high plane and of the greatest value to the modern physician.

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*A Text-book of Obstetrics.* The New (8th) Edition. A Text-book of Obstetrics. By BARTON COOKE HIRST, M.D., Professor of Obstetrics in the University of Pennsylvania. Eighth edition, revised and reset. Octavo of 863 pages, with 715 illustrations, 38 of them in colors. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, $5.00 net. The J. F. Hartz Co., Limited, 24-26 Hayter Street, Toronto, Sole Canadian Agents.

The appearance of an eighth edition of this well-known text-book of obstetrics should be a sufficient evidence of its hold upon the student and practitioner. This book is essentially a very personal one, reflecting the author's large experience in obstetrics and obstetrical surgery—a fact which without doubt accounts considerably for its popularity.

For the present edition not very much of new material is presented. The effort has been to condense wherever possible. Recent proved advances are incorporated, and references given. The illustrations are particularly good, and are an education in themselves.

*A Diabetic Manual for the Mutual Use of Doctor and Patient.* By Elliott P. Joslin, M.D., Assistant Professor of Medicine, Harvard Medical School. Philadelphia and New York: Lea & Febiger, 1918.

Diabetes draws its victims very largely from the educated classes, so that a book such as this is of the greatest importance, for the patient has a chance to review the things he has been told by his physician. In 175 pages Dr. Joslin tells in simple language all a patient needs to know about his disease. One portion of the book is devoted to a diabetic menu and food values, another to laboratory tests. This is a most excellent work to put in the hands of one suffering from this rather common disease.

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*A Treatise on Clinical Medicine* (Second Edition, Revised). By William Hanna Thomson, M.D., LL.D., formerly Professor of Practice of Medicine and of Diseases of the Nervous System, in the New York University Medical College; ex-President of the New York Academy of Medicine, etc. Second Edition, Revised. Octavo volume of 678 pages. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, $5.50 net. The J. F. Hartz Co., Limited, 24-26 Hayter Street, Toronto.

This book is especially suited for the general practitioner. The subject matter is well handled in a clear, concise, and practical manner. We think that the portions dealing with Diagnosis and Treatment, respectively, are worthy of high commendation.

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*The Ungeared Mind.* By Robert Howland Chase, A.M., M.D., Physician-in-Chief Friends' Hospital (for Mental Diseases), formerly Resident Physician, State Hospital, Norristown, Pa., etc. Illustrated. Philadelphia: T. A. Davis Company, publishers; 1918.

This is a collection of several semi-scientific, popular writings on various mental states. The different manifestations of insanity are exemplified, and the nature of the departure from the normal demonstrated. The titles of some of the chapters will give a general idea of the subject-matter: Some Ques-

tions Relating to the Insane, Care of the Mind, Delusions of the Insane, Legal Aspects of Mental Deficiency, A Study of the Dying State. To the physician, this book is interesting and enjoyable, while to the layman it presents in an easily-read fashion an important aspect of medicine.

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*Human Intestinal Protozoa in the Near East.* An inquiry into some of the problems affecting the spread and incidence of intestinal protozoal infections of British troops and natives in the Near East, with special reference to the carrier question, diagnosis and treatment of amœbic dysentery, and an account of three new human intestinal protozoa. By Temp. Lieut.-Colonel C. M. Wenyon, B.Sc., M.B., B.S., Royal Army Medical Corps, Member of the Medical Advisory Committee, Director of Research in the Tropics to the Wellcome Bureau of Scientific Research; and Temp. Capt. F. W. O'Connor, M.R.C.S., L.R.C.P., Royal Army Medical Corps. Published for the Wellcome Bureau of Scientific Research, 10 Henrietta St., Cavendish Square, London, Eng. John Bale, Sons & Danielsson, Limited, 83-91 Great Titchfield Street, London, W.

This book contains a summary of work done on the intestinal protozoa, together with a report on an excellent research carried out on soldiers. The results should be of great benefit to those who have to spend some of their days in these infected regions.

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*Differential Diagnosis.* Presented through an analysis of 317 cases. By Richard C. Cabot, M.D., Assistant Professor of Clinical Medicine, Harvard University Medical School. Volume 2, Second Edition. Octavo of 709 pages, 254 illustrations. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, $6.00 net. The J. F. Hartz Co., Limited, 24-26 Hayter Street, Toronto, Sole Canadian Agents.

Cabot's method of studying cases, with a large hospital at his command, is most interesting. These two volumes are too well known to need comment. Each case described is as interesting as a problem in mathematics, and the answer is at the end. The histories of the 317 cases are so well written that they serve as models for students.

*The Elements of the Science of Nutrition.* Third Revised Edition, Enlarged. By Graham Lusk, Ph.D., Sc.D., F.R.S. (Edin.), Professor of Physiology at Cornell Medical School, New York. Third edition, reset. Octavo of 641 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1917. Cloth, $4.50 net. The J. F. Hartz Co., Limited, 24-26 Hayter Street, Toronto, Sole Canadian Agents.

Dr. Lusk's work has been a classic for nearly a generation. This third revision, which he says will be the last, brings the book up to date and makes it still the leader on this side of the water. Every possible phase of nutrition is dealt with minutely, in a style both clear and readable. When all economic leaders are thinking in calories during this great war, a book such as this is particularly valuable.

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We offer our thanks for a copy of the Transactions of the American Pediatric Society for the year 1917, to Dr. Howard C. Carpenter, the Secretary of the Association.

It is generally recognized throughout North America that the work which has been accomplished by this Society is admirable in all respects.

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*A Pocket Formulary.* By E. Quin Thornton, M.D., Assistant Professor of Materia Medica in the Jefferson Medical College, Philadelphia. Eleventh edition. Revised. Lea & Febiger, Philadelphia and New York, 1918.

This Formulary, which has now reached its 11th edition, is in our hands. That it should reach such an edition speaks of itself of the value of the work. It is up-to-date and includes the treatments of the Sera, the Vaccines and Salvarsan, etc. When one is looking for help in reference to the complicated case a volume of this kind is of the greatest value and is a splendid addition to the desk of every practitioner.

## ONTARIO MEDICAL COUNCIL

The Annual Meeting of the Ontario Medical Council was held June 25th to June 27th, 1918.

The officers elected were: President, Dr. R. Ferguson; Vice-President, Dr. A. T. Emmerson; Registrar-Treasurer, Dr. H. Wilberforce Aikins; Solicitor, H. S. Osler, Esq., K.C.; Auditor, James F. Lawson; Stenographer, George Angus; Prosecutor, John Fyfe.

The following medical Colleges in the United States were added to the list of accredited colleges in Ontario:

1. Hahnemann Medical College of Philadelphia;
2. University of Michigan Homœopathic Medical School;
3. Boston University School of Medicine.

The Council passed a resolution asking the Militia and Defence Department to "reconsider the regulations relating to medical students under the Military Service Act."

The depletion of the profession throughout the Dominion by the demands of the military services, and the reduction of the number of students in attendance at medical schools by voluntary enlistment and conscription, has created a situation which must result in a complete breakdown of medical services, both civil and military, in the near future.

"The Council desires to represent to the Department of Militia and Defence the necessity of immediately making provision to continue the education of a sufficient number of students.

"The Council is of the opinion that young men who completed their preliminary education and entered upon the study of medicine before attaining military age, should be permitted to continue professional studies, and that this policy should be applied to the matriculation classes of this and subsequent years.

"In January last the British War Office intimated that Canadian medical students who had completed one year of study, and who were in any branch of military service overseas, would be permitted to return to Canada to resume their studies. In view of the gravity of the situation, this Council requests that this privilege be extended to men who are in service overseas, and who, prior to enlistment, had completed matriculation in Medicine or had entered upon Arts or Science courses, in preparation for the study of Medicine. It is sug-

gested that the staff of the Khaki University assist in the selection of these men."

The following resolution was passed: "That whereas the medical examinations of the manhood of Canada, for military service, reveal a serious percentage of physically unfit, varying from forty per cent. to seventy per cent., this Ontario Medical Council is of the opinion that some form of supervision of the health of the country should be instituted by the State, and suggests that this matter be referred to the proper departments in the Dominion and Ontario Governments."

It was decided to ask the Federal and Provincial Governments to modify the Patent Medicine Act, so as to prevent the misbranding of proprietary medicines, and the publication of "fake" testimonials, etc.

The following are extracts from the report of the Special Committee appointed to consider the attitude which the College assumes toward the observance by its members of the provisions of the Ontario Temperance Act: "The Medical Council are of opinion that the giving of orders by medical men for the obtaining of alcoholic liquor is justified in any case in which the medical man is satisfied, 'of his own knowledge,' that the use of alcoholic liquor is necessary and proper for the treatment of the patient; and

That this Council would deprecate the giving of such orders upon any other ground whatever.

The Medical Council would request that the Board of License Commissioners take such steps as may be necessary to ensure that liquor sold on such orders be of proper quality and purity.

That means be taken by the Board of License Commissioners to investigate and deal drastically with all cases in which the provisions of the "Ontario Temperance Act appear to be subverted."

"We are of the opinion that the quantity of alcoholic liquor for internal use should be limited to eight ounces."

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P.—4

# Miscellaneous

### Acute Metatarsal Overstrain (Foot-swelling)

A. Rocyn Jones describes the case of a soldier in which a provisional diagnosis of trench feet was made. An X-ray examination, however, showed fracture of the second metatarsal bone in each foot. He points out that marching fractures seldom occur in both feet and gives the figures of Nion, who found that out of 575 cases in two only were both the second metatarsals affected, in one both the third, and in one the second and third. Rarely are there two fractures in the same foot, either, and in Nion's series the second and third metatarsals were broken only in four cases, and the second and fourth in one case. Acute metatarsal overstrain is practically confined to the three middle metatarsals and Nion gives the proportions of 112:98:17 for the second, third, and fourth metatarsal, respectively. Rocyn Jones points out that the second metatarsal bone is the one most subject to variation; it may be the strongest next to the first metatarsal, or it may be the weakest. The third is always a weak bone. The frequency of fracture of these bones is due to their commonly slender length, their fixity, their direct forward projection, their line in the transmission line of body weight, and the part they play in the leverage action of the foot. The development of symptoms, as a rule, is gradual during a march, and there is rarely any account of accident. The pain is localized to the metatarsus, and by running the fingers along the bony shafts a very sensitive spot will be found in one of them. If a fracture occurs, discoloration of the skin due to extravasation of blood may be present and possibly crepitus elicited. Swelling of the foot is usually a prominent feature. The diagnosis can only be definitely established by the X-ray. If there is no fracture periostitis may be present and is shown in the skiagram by vagueness and irregularity of outline. The condition occurs more frequently in troops from lowland than from mountainous districts, for hill climbing tends to strengthen the metatarsus and pedal muscles, and possibly to promote a better power in dorsiflexing the foot. *Treatment*: Complete rest off the feet for four weeks, and the application of massage and hot air. The heating chamber should be at a temperature of 300° Fahr., and the limb well protected by wool and flannel bandages. Treatment should occupy from thirty to forty minutes daily. As an alternative

# Appointments as Medical Examiners

The Empire Life Insurance Company of Canada has been formed under Dominion Charter with the special object of granting insurance to under-average lives.

## Ninety-Three Years' Experience in Sub-Standard Risks

The Clerical, Medical and General Life Assurance Society of London, England, was organized in Great Britain in the year 1824, with the same object that the Empire Life is founded to-day in the Dominion.

This company was in fact founded to grant life insurance to persons below the average standard of fitness imposed by the ordinary life offices of that day. By its Act of Incorporation, eight of the Board of Directors must always be members of the Medical Profession. The long list of eminent physicians and surgeons who have served in this capacity is a recital of the leaders of the medical profession in Great Britain during nearly a century. Sir Richard Douglas Powell, (Bt., K.C.V.O., M.D., Physician in Ordinary to H. M. the King), is the present Vice-President of the Society.

It is upon the broad lines which this great company has proved scientifically and commercially successful, that the Empire Life Insurance Company of Canada purposes to proceed, and thus extend in the Dominion the protection of life insurance to a large class from whom it has hitherto been withheld.

## Medical Examiners Appointments

Members of the Medical Profession are particularly invited to apply for full particulars as to appointments and investment.

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treatment passive hyperæmia may be adopted. A Martin's bandage is applied round the leg just above the ankle, so as partly to obstruct the venous flow from the foot. This treatment should be applied first for an hour daily and gradually extended to several hours. At the end of one month or less in the case of periostitis the patient is allowed to get on his feet gradually, and ten days later, if there is no pain or swelling, to walk freely. In the case of fracture a transverse "football" bar may be worn for a few weeks and then discarded. Care should be taken that a properly fitting boot is provided.—*Medical Record* (*British Medical Journal*).

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### Definition of Trench Fever

As no pathognomonic symptom of trench fever is at present recognized, we would define the disease as a blood infection communicable from man to man by means of the louse and possibly other parasites. It is characterized in its early febrile stage by recurrent pyrexia, headache, giddiness, pain in the back, pain in the limbs, chiefly legs, a slow pulse, sweating, polyuria, a moderate leukocytosis, with evidence of blood infection in involvement of the spleen and liver. A certain percentage pass into a state of chronic ill health. These suffer from recurrent pains in the limbs, headaches and nervous manifestations, such as mental depression, excessive tendency to sweating, disordered action of the heart, accompanied by a mild anæmia. The infection in some cases is very persistent, and relapses may occur after months of quiescence.—*Report Committee, Hampstead, Eng.*

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### Tuberculous Endocarditis

Marchiafava (in *Med. Nuova*) records the case of a patient, twenty-nine years of age, who came to hospital in a condition of cyanosis, with small and rapid pulse, and dry cough. At the autopsy there were found a tuberculous circumscribed lesion at the apex of the right lung, and miliary tubercles scattered throughout both lungs. The peribronchial and peritracheal glands were enlarged, hyperæmic, and infiltrated with miliary tubercles. The intestinal and mesenteric glands were normal. The heart, especially the right ventricle, was dilated. The mitral valve showed evidence of tubercle bacilli on microscopic examination.—*The Prescriber.*

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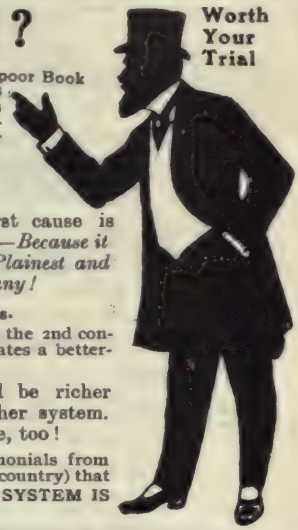

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### Certain Views of Shock

Luzoir writes upon a subject of immediate importance, for the French surgeons are skeptical about shock as an autonomous condition and would substitute shock—like states of various sources. In Gwathmey's book on Anæsthesia, he finds a minute study of shock *per se,* which varies only with the cause. The practical view of shock as something which can in part be averted by anoci-association is conceded by French surgeons. This psychic component is naturally not the whole of shock. Peripheral irritation and the action of large doses of poisons are separate components. The less severe burns cause more shock than the deeper ones. Crile has shown that irritation of organs may raise or lower the temperature, according to the organ tested. There is a shock component in severe poisonings, whether corrosive only or true systemic intoxications. Crile has shown that duration of an operation must be a shock factor, and this introduces the anæsthesia component. The general anæsthetics are peripheral irritants as well as poisons, hence doubly disposed to aid in the production of shock. Moreover, during a long operation the subject is exposed more or less to the air and loses heat, although subnormal temperature is a symptom of shock. Gwathmey isolates anæsthetic shock from surgical shock—it may readily be studied in non-traumatic cases and with a variety of anæsthetics. Operative shock can hardly be studied without anæsthesia, but shock under mild anæsthesia

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is due to the incompleteness of the anæsthesia, plus—in certain cases, such as laparotomies—manipulation and tugging of the viscera, this mechanical element acting as a hindrance to respiration.—*Medical Record.*

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### Digitalis and the Control of Auricular Fibrillation and Auricular Flutter

In the *American Journal of the Medical Sciences* for March, 1918, Halsey points out that many cases of flutter have been reported which have been changed to fibrillation, and subsequently, after slowing by digitalis, have resumed their normal sequential rhythm. This is the aim and hope of the procedure.

The employment of digitalis to effect the rhythm as shown in these cases should not permit us to forget that such use depends on the accurate diagnosis of the condition. If there is doubt as to the cause of pulse-frequency one should hesitate in the administration of such doses of digitalis, for the production of fibrillation in an otherwise healthy heart would not be desirable nor justifiable.

1. The gross irregularity of the ventricle in cases with fibrillation of the auricle can be controlled by digitalis if sufficient drug is exhibited.

2. The patient should be instructed to continue the use of digitalis for the remainder of life, and should be taught how to determine the amount of the dose necessary from day to day to control the heart-rate. Give sufficient drug to maintain the rate of the ventricle below 70 per minute when counted after a rest in the late afternoon.

3. The fibrillating auricle under a short course of digitalis may return to normal rhythm.

4. In auricular flutter the aim of treatment with digitalis is to produce auricular fibrillation and then control the rate of the ventricle with digitalis, hoping in the favorable cases for a renewal of normal sequential rhythm.—*Therapeutic Gazette.*

---

### Blood Pressure of Pregnant Women

Danforth's observations in a series of 115 cases showed that the average blood pressure of the pregnant woman is less than that of the non-pregnant. Labor causes in many cases a rise of arterial tension. Toxæmia of pregnancy is accompanied by a rise of blood pressure, except in very rare instances, and this rise usually precedes other symptoms.—*Amer. Jour. Obstet.*

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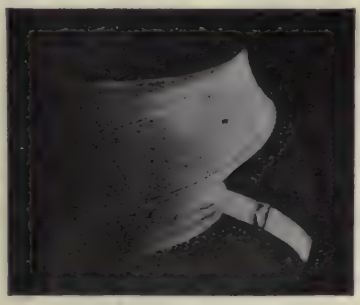

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## Joint Surgery

We have always considered infection of joints as one of the most fruitful problems for surgical study. There is scarcely a phase of the problem concerning which opinion has even reasonably settled; the pathology. The effect of lesions of the various component parts of the joint upon end function. The diagnosis, especially in relation to the utility of diagnostic puncture and, above all, therapy. Witness, for instance, even in the most recent years, how rapidly our therapeutic notions, concerning the treatment of infected joints, have fluctuated. First, we had "button hole" through and through, and long continued drainage, ending almost invariably (if the patient's life was spared) in firm ankylosis. Then came the wide mutilating open Mayor operations, which gave a lower mortality, but left the joint in even a firmer ankylosis. Then followed the injection procedures of Murphy which, while occasionally followed by brilliant results, not infrequently ended disastrously. The present status of the treatment of joint infections is in anything but a crystallized state, but it is hoped that the numerous opportunities furnished by this war will enable us to utter fairly definite convictions upon this subject. Our thoughts reverted to this topic in reading the unusually clear and well-written paper of Elœsser (*Boston Medical and Surgical Journal*, April 25, 1918), based on an extensive and keenly-observed experience during the present war.

Elœsser starts out with the pregnant remark that the difficulties in treatment are largely mechanical; a joint is not a cavity but a series of more or less intercommunicating cavities. Furthermore, he makes a very apt comparison between the analogy of a joint and of the peritoneal cavity, and shows that we must regard the endothelial lining of the joint with the same respect as we have learned to deal with the endothelium of the peritoneal cavity. Elœsser classifies the sources of infection of a joint into four types: 1. Direct, by means of a missile; 2. Indirect, through a fissure in the bone; 3. Secondary, by spread of a neighboring suppuration; 4. Metastatic. The recognition of these various modes of infection is highly important, not only from a theoretical, but from a practical viewpoint. It is obvious, for instance, that if there is direct infections from without, the offending material must be removed as soon as possible. If there is, on the other hand, indirect infections from communicating bursæ or joint fractures, the primary focus must be treated; resect, if necessary; resect pro-

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phylactically if manifestly infected. The third type—secondary indirect infection from neighboring abscesses—is fortunately rare. The dominant principle in this form of infection is to leave the joint alone unless it is surely involved. For metastatic infections, the indication is simple: evacuate the pus.

Whatever the origin of those infections, all may lead to similar pathological lesions. It is important, however, to recognize two distinct groups. The first is the suppurative form without deep involvement of the joint capsule; the second, the dry form, in which the capsule has become phlegmonous. "The whole future of the joint depends whether it is to be movable or permanently stiff and crippled, depends on whether the capsule is deeply involved or not—whether the bacteria are merely in the joint cavity or whether they have wandered out of the cavity and infiltrated the capsule."

We now come to Elœsser's method of handling a joint containing frank pus—a joint empyema. After removal of the foreign body, the pus is drained off; *the joint, however, should not be left open.* Here, again, Elœsser argues that the treatment of a pus joint should conform to the principles which we have learned in treating a peritonitis. The now well-established dictum, "Allow the peritoneum to take care of itself," should be applied to the treatment of prevalent infections of a joint. We have long ago learned that if the cause of a peritonitis is removed, no extensive drainage or irrigations are necessary. So with a joint. "If it is kept open, exposed to the air or covered with gauze, both synovia and cartilage are lost—and the joint obliterates." Therefore, Elœsser recommends, let the pus out through a small stab, leave in a small drain until the pus disappears, and the discharge becomes serous. The drain is then removed and the joint allowed to close up spontaneously. Distension of the joint frequently ensues, and the patient may even run a fever. This, however, should not alarm the surgeon; the fever subsides in a few days, and at the same time the swelling may recede. Elœsser is not positive as to whether irrigations are necessary or not; he believes that probably the Carrel-Dakin solution is the best antiseptic to use.

If the joint is an extensive series of cavities, it is important to recognize which portions are infected and which are not; only those portions that are infected are drained; the others are not, and he emphasizes the importance of not employing any procedures that may carry infection from infected to the non-infected areas.

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In discussing the treatment of the second form of infectious arthritis, that associated with a capsular phlegmon (the clinical phenomena of which are set forth by the author in a masterly form), Elœsser says that the treatment is beset by many difficulties. "One will never cease to have patients who, whether they recover or succumb, one would wish to have treated otherwise." In these infections, the primary indication is to save life; the joint is hopelessly lost from the outset. The joint is, therefore, widely drained, all foci of necrosis and foreign bodies are removed, and the joint is filled or irrigated with the Carrel-Dakin solution. The limb is immobilized and must not be disturbed for unnecessary dressings. Too many are worse than too few. The difficulty is in knowing when amputation is necessary, if we decide too late, the man is lost; if we decide too early, a limb that might have been saved is sacrificed.

The remainder of Elœsser's article contains many specific directions for the treatment of individual joints, which we recommend those specially interested in this topic to read. There is but one other point which we deem sufficiently important to mention, and that is, the advisability of removal of all foreign bodies within the joint, even if they have aseptically healed in. Such foreign bodies are very apt, in time, to cause roughening of the articular surfaces eventually resulting in a chronic deforming arthritis. Lead foreign bodies are particularly dangerous. The lead dissolves in the synovial exudate and settles as a greyish white deposit under the capsule. Such joints develop an uncommonly severe form of hypertrophic arthritis.—*American Journal of Surgery.*

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**Entirely Reasonable**

The superintendent of a large hospital for the insane in the Middle West was walking through the large congregate dining-room, greeting the various patients at their meal, when he came to a middle-aged woman suffering from melancholia, who was emptying the contents of a salt shaker into her glass of water. The doctor asked, "Why are you putting salt into your water?" To which the agitated woman replied, "Well, you know, doctor, I have tried every way I know to commit suicide, but they always prevent me, so I have decided to drink salty water and die from thirst."

## Doctor,—

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### Neuropathic Diathesis in Infant

Rueda remarks that it is impossible to foretell how infants in this category will react to different elements in the milk. He insists, however, that sooner or later every infant reaches a point when cow's milk is borne well. A typical instance of neuropathic taint is described. The infant was over two months old, but he could not stand his mother's milk or any breast milk. The fat in it seemed to be responsible for the pallor and syncopes which followed the feedings. These and absolute intolerance for breast milk subsided when the child was given sweetened skimmed cow's milk and later, sweetened breast milk, from which the fat had likewise been removed, with addition of some heterogenous albumin, until pure cow's milk could be substituted for the latter. The child has been thriving constantly during the six month since.—*N. Y. Medical Journal.*

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### He Caught the Pneumonia—The Mastoids were a Gift

Rome, May 1.—Nelson J. Smith, 17, son of Mr and Mrs. Clarence D. Smith, of Lake Delta, died Monday night in a hospital at the navy yard at Newport. He had an attack of pneumonia about six weeks ago, which left him with mastoids behind the ear and he was operated on, death following.—Syracuse (N.Y.) *Herald.*

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### No Flattery

Wife—"Hello! Dr. Bunyun? Yes? Come right away. Mr. Little has another one of his spells."

Doctor (half an hour later)—"Why didn't you send for me sooner? You should not have waited till your husband was unconscious."

Wife—"Well, as long as he had his senses he wouldn't let me send for you."—New York *Evening World.*

# The Canadian Practitioner and Review

Vol. XLIII. TORONTO, OCTOBER, 1918 No. 10


## Original Communications

### MENDELISM


By James Roberts, M.D., Hamilton Medical Officer of Health.


Mendelism or Mendel's Law is a term used to designate certain principles of heredity discovered by Mendel and enunciated by him before the Scientific Society of Brün, Austria, in 1865.

The Abbe Gregor Johann Mendel was a teacher of the physical and natural sciences in a monastic school. His experiments were performed on garden peas which he grew in the garden of the monastery. His conclusions, unknown to Darwin and to nearly all the great naturalists of his time, remained unnoticed for thirty-five years, until as a result of the steady advance of biology, Mendel's Law was rediscovered in 1900 simultaneously by Correns in Germany, Tchermak in Austria, and DeVries in Holland.

As already observed, Mendel's own results were obtained by cross fertilization between different varieties of *Pisum Sativum*, or the edible pea. Every gardener is probably familiar with the tall and dwarf varieties of peas. The tall peas grow to a maximum height of from six to eight feet, the dwarf variety does not grow to a height of more than one or two feet above the ground. The difference between a tall and dwarf pea is not comparable to the difference between a normal and a dwarf person. In a dwarf man we have a diminutive man, a miniature edition, as it were, of a normal sized man. A dwarf pea differs from its tall relation in one particular of its structure only as far as appearance goes, namely, in the length of the sections of stem between successive nodes or points where the leaves are given off. Both tall and dwarf

varieties of peas are normally self fertilized, i.e., in both varieties pistil and stamens are found on the same blossom and fertilization takes place by the escape of pollen from the stamens of a particular flower to the stigma and thence to the ovary of the same flower.

Seed collected from dwarf peas gives rise when sown to dwarf plants only, and seed sown from tall plants gives rise to tall plants only. Either kind of plant when left to itself is said to breed pure or true.

If pollen grains taken from the flower of a tall plant be artificially transferred by special methods of the practical breeder, to the female organ of a dwarf plant, the plants which result from the cross carried out in this way are always tall. Such tall peas, with the exception of being perhaps somewhat taller and more vigorous, are identical in appearance with their pure tall parents and are known in technical language as the first hybrid or filial generation. If now these hybrid talls are allowed to self fertilize and seed collected in the autumn be sown in the following spring, the plants so produced will be found to be of two kinds, one indistinguishable from the tall grandparent, the other the counterpart of its dwarf ancestor. Moreover, about three-quarters of the plants of this second hybrid or filial generation are tall and about one-quarter are dwarf. In other words, the ratio of talls to dwarfs is three to one on the average.

Let us now consider the result of allowing the plants of the second hybrid generation to self fertilize. The seed sown from the dwarfs produces dwarfs, which accordingly are pure and breed true, exactly as did the dwarfs with which we began the original cross.

If we inquire into the nature of the talls in the second hybrid generation, three possibilities present themselves: They all may be pure; all may be hybrid; some may be hybrid and some pure. The latter possibility is found to be the true one. Two of the three are hybrid and by self-fertilization, therefore, give rise in the third hybrid generation to talls and dwarfs in the ratio of three to one respectively. The remaining tall is pure, and left to itself produces only talls.

Summing up, then, the results of Mendel's observations on the crossing of a pure tall with a pure dwarf variety of pea, and assuming for purposes of explanation that in the first and subsequent generations after the original cross, that only four offspring are produced, we find by the mating of a male tall with a female dwarf, or vice versa, that the resulting four

progeny of hybrid generation No. 1 are all tall and hybrid. Any one of these being left to fertilize itself produces tall and dwarfs in the ratio of three to one. Of the three talls in hybrid generation No. 2, one will be found to be pure, the other two hybrid; or, in other words, the four individuals in No. 2 are numerically distributed as follows: One pure tall, one pure dwarf and two hybrids. These hybrids on again being permitted to fertilize naturally, will give rise to a third hybrid generation, consisting of one dwarf and three talls, as in the preceding instance. In like manner, by the self fertilization of the hybrids in any generation the same mathematical results as were secured in the second may be indefinitely reproduced.

Mendel himself made 37 crosses between tall and dwarf. He does not state how many of these were successful. His second hybrid generation consisted of 1,064 plants, of which 787 were tall and 227 were dwarf. *One hundred* of the 787 talls were set apart and from each of these ten seeds were selected and sown. *Twenty-eight* of the *hundred* produced talls; *seventy-two*, talls and dwarfs. It will therefore be seen that of the *hundred* talls in the second hybrid generation selected by Mendel and tested, the number of pure talls was too low, while the number of hybrid talls was too high. To the importance of this fact we will call attention later on.

Mendel made crosses between peas which differed in other respects than tallness or dwarfness. In every instance the characters with which he experimented were considered in pairs, or in other words the characters investigated were chosen with reference to the same part of the plant—to the stem, pods, cotyledons or seed coats. The six other features of the culinary pea with which Mendel dealt in his work were as follows: Normal and fasciated stems, hard and soft pods, yellow and green color of the unripe pod, grey and white color of the ripe seed coat, yellowness and greenness as to color, roundness and wrinkledness as to shape, of the cotyledons or first two leaves of the pea plants. Mendel crossed a variety having a fasciated stem with a variety the stem of which was normal. The stem of the hybrid produced by the cross was found to be normal. In the second hybrid generation there were 651 normal and 257 fasciated plants. Of the 651 normal ones, only 100 were tested, as in the case of the tall and dwarf. The offspring of 33 of the hundred were normal without exception, and therefore pure. The offspring of the remaining 67 were sometimes normal and sometimes fasciated in the case of every plant. In

other words, 100 out of 651 normal plants of the second hybrid generation tested by Mendel produced on the average two offspring that were hybrid to every one that was pure.

Mendel crossed a green podded with a yellow podded variety of pea and found the offspring to be green podded. In the second hybrid generation there were 428 plants with green pods and 152 with yellow ones. Seeds from 100 of the green podded plants were sown as in the two preceding instances, and of the hundred plants 40 were found to give rise to green podded plants only, and 60 to both green and yellow podded ones.

We are now in a position to recognize another feature which results from the crossing of a variety of pure race, bearing one characteristic of a pair, with another variety of pure race bearing the opposite characteristic of the same pair. In crosses of this kind it may be stated in general terms that the resulting hybrid bears one of the characteristics of the pair to the complete exclusion of the other as a rule. That character of a pair which completely or partially excludes the other of the pair in the hybrid is called the *Dominant* member of the pair; the other character is called the *Recessive*, because it disappears from sight in one generation only to appear in the next.

Mendel's observations then may be summarized briefly as follows: If an individual bearing a *dominant* character be crossed with an individual bearing a *recessive*, the resulting hybrids, called hybrids of the first generation, will all bear the dominant character. The second hybrid generation or offspring of individuals of the first will be dominant and recessive, three dominant to one recessive on the average. Of these dominants one is pure and mated with its like will give rise to dominants only. The other two are hybrid, and will produce dominants and recessives in the proportion of three to one.

Most of the results that have been described differ widely from what ordinary notions of inheritance would lead us to anticipate in the experiments performed. Earlier observers were inclined to think of the union of opposite characters in reproduction as producing on the whole a blend of the two characters, much as when two liquids of different color mix to produce a third color or blend of the original two. Many hereditary qualities behave after this fashion. The cross between a negro and white is a mulatto. Mulattos when bred together produce mulatto children—the two parental characters having apparently blended. Characters which conform to the Mendelian law do not ordinarily mix or blend. These

characters are sometimes known as *"unit characters"* and behave in reproduction like separate entities or parts of a structure which may be placed together and taken apart like the blocks of a child's playhouse.

A typical example is given by the cross between a common grey mouse and an albino mouse of the same extraction. If a grey mouse be mated with a white, the resulting hybrid does not show a mixture of the grey and white and be whitish grey in color, but appears pure grey. The hybrid does not lack the white of the albino. It is only dominant or concealed, and may be recovered again in the next generation. We have only to mate the grey hybrids together, when it will be found that the progeny will include eventually, if sufficient animals are bred, a certain number of whites. These white mice when mated with one another produce whites only for any number of generations and are identical in appearance with their white ancestry.

The scope of a ten minute paper will not allow us at this time to give further examples of a phenomenon which occurs very widely in plants and animals and can be illustrated by a great variety of characters. Some examples of Mendelian inheritance which may be observed in animals are: Color of the coat in rabbits, guinea pigs and mice; length of hair and smoothness or roughness of coat in guinea pigs; waltzing or normal progression in mice: the color patterns of butterflies and snails; the color of plumage and structure of the comb in fowls. Examples to be found among plants are: Bearded and beardless varieties of grain; shapes of leaves; color of flowers; color and shape of seeds. All of these examples, and many others that might be mentioned, are cases where two contrasting or opposite characters present themselves in such a way that when two individuals being opposite characters are crossed, the resulting hybrids bear the *"dominant"* character, while the offspring of these first generation hybrids show the *Dominant* and *Recessive* character in the ratio of 3 to 1. Evidently we are dealing with appearances concealing some deep hidden principle of inheritance for which the Mendelian hypothesis may be looked upon as an explanation much in the same way as the formulas of organic chemistry afford an explanation of the experimental results in this field.

Three discoveries of modern biology are essential to an intelligent understanding of inheritance as manifested in the examples already chosen. These are: (1) The fertilization of

egg; (2) the maturation of the egg, and (3) the non-inheritance of acquired characters.

It has been shown in recent years that in the reproductive cells the nuclear material becomes doubled in amount at fertilization, equal amounts being contributed by egg and sperm. This duplex condition appertains to all parts and tissues of the body and lasts throughout the life of the new individual. When, however, this individual in turn contributes to the production of another individual, its eggs or sperms, as the case may be, before taking part in reproduction become reduced to the single condition. This reduction process is known as *Maturation.* In the case of the egg we have two divisions, with the formation of two smaller cells or polar bodies, which take no part in the formation of the embryo. The chromosomes left in the egg after these two divisions are only half as numerous as before. Similar changes occur in the male or sperm cells. After a series of changes, involving two cell divisions, the products of the original cell contain half the original number of chromosomes. Eggs and sperms then previous to their union in fertilization are said to have their chromotin in the single or reduced condition, while the individual which develops subsequent to such union is in the double condition. In bees, however, to cite a single example, the egg may under certain conditions develop without being fertilized. If the egg develops while in this double condition the offspring produced is a female, like the mother; but if reduction takes place to the single condition before the development of the egg, the resultant individual is a male.

An egg or sperm which is in the reduced condition ready to take part in reproduction is called a *gamete.* The result of the union of two gametes, egg and sperm, is a *zygote,* an organism which is at first a single cell.

If a black guinea pig of pure race be mated with a pure white guinea pig, the offspring will all be black. The black character dominates in the cross; the white recedes from view. The black character is therefore dominant; white is the recessive character. But if now two black individuals of the first filial generations be mated with one another, the offspring will be one white to three black on the average. In the original cross the gametes which united were one black, the other white. In the resulting zygote the black and white are associated together in the germ cells; black dominating white. If such zygotes, on becoming adult, form gametes, the white and black again separate from one another and pass into separate cells.

The gametes formed by a female hybrid black are half of them black, the other half white. Similarly, the gametes formed by a male hybrid black are half white and half black.

Three principles of Mendel's Law are illustrated in this cross: (1) The existence of unit characters, (2) Dominance, (3) Segregation of the units among the gametes formed by the progeny of the original cross.

Now in the union between the blacks of the first generation, the following combinations of gametes or factors are possible:

Black borne by ovum with black borne by spermatozoon.
Black borne by ovum with white borne by spermatozoon.
White borne by ovum with black borne by spermatozoon.
White borne by ovum with white borne by spermatozoon.

These four kinds of union are on the average equally frequent. This statement may be illustrated best perhaps by the tossing of coins. If two persons each take a coin and toss it at the same time, say a thousand times, the result of any given toss may be one of three things—head head, head tail or tail tail. But the total result of 1,000 throws will not be very far from 250 head head, 500 head tail and 250 tail tail.

The combinations of egg and spermatozoon which would naturally therefore be produced in one cross—BW and WB being the same, since reciprocal crosses are identical, are 1 BB, 2 BW and 1 WW or 1 pure black, 2 hybrid black and 1 pure white. This ratio does not often appear in a single litter or in a few litters, but in a large number of litters taken together it holds good with remarkable accuracy.

Hair length is a unit independent of hair color. If a short haired dark animal be mated with a long haired albino, the first hybrid generation are short haired and dark. The second hybrid generation may be predicted from the zygotic formula of the first L.S. W.D., and accordingly will be of four sorts: (1) Dark and short haired, (2) white and short haired, (3) dark and long haired or (4) white and long haired.

Dominants will be to recessives as 3 to 1; therefore, dark haired will be three times as numerous as white, and short haired 3 times as numerous as long haired. Short haired and dark animals will be three times three or 9 times as numerous as long haired and white, and in a large number of groups taken collectively, a group of 16 individuals will contain representatives of the four classes 1, 2, 3, 4, already mentioned, in

the proportion of 9, 3, 3, 1, respectively. This is known as the normal Mendelian dyhybrid ratio.

With three pairs of characters, e.g., a long haired, white, rough individual mated with a short-haired, dark smooth, we should get in every 64 of the offspring of the second hybrid generation 27 S.D.R., 9 L.D.R., 9 S.W.R., 9 S.D.Sm., 3 L.W.R., 3 L.D. Sm., 3 S.W.Sm., 1 L.W.Sm., and so on with four or more factors.

Given *dominance* and *recessiveness* between characters, therefore, the breeder's predictions become a computation in mathematics.

Such is the Mendelian principle in its simplest form, as stated by Mendel himself. Up to Mendel's time the problem of the biologist was to find how the characters of the parent got into the germ cells of the next generation. Darwin's "pangenesis theory" was an attempt to solve the problem. Weismann put the problem in another way in his "theory of the continuity of the germ plasm." Weismann contends, in the words of Butler, "the riddle is not that a hen produces another hen through the medium of an egg, but that a hen is merely an egg's way of producing another egg." Then hen, according to this theory, is merely a fluffing up of the germ plasm and is mortal. The germ plasm is immortal. Mendelism is a confirmation of Weismann's theory.

Already in the few years that have elapsed since the rediscovery of Mendel's papers a vast number of facts relating to the inheritance of characters have been accumulated. All of these are of scientific and many of utilitarian interest. Time will not permit me to dwell on these points. I am not a biologist and have not had opportunity of dealing with this subject in an experimental way. My only excuse for bringing it before you may perhaps be best illustrated by the words of a standard authority on heredity: "The existence of civilized man rests ultimately on his ability to produce from the earth in sufficient abundance cultivated plants and domesticated animals. City populations are apt to forget this fundamental fact and to regard with indifference, bordering at times on scorn, agricultural districts and their workers. But let the steady stream of supplies coming from the land to any large city be interrupted for only a few days by war, floods, a railroad strike, or any similar occurrence, and this sentiment vanishes instantly. Man to live must have food, and food comes chiefly from the land."

A knowledge of how to produce useful animals and plants

is therefore of prime importance. Civilization had its beginning in the attainment of such knowledge, and is limited by it at the present day. If, therefore, this knowledge can be increased, civilization may be advanced in a very direct and practical way. Before Darwin the practices of animal and plant breeders were largely empirical, based on unreasoned past experience, just as was in antiquity the practice of metallurgy.

The evolutionary idea had forced man to consider the probable future of his own race on earth and to take measures to control that future, a matter he had previously left largely to fate. With a realization of the fact that organisms change from age to age and that he himself is one of these changing organisms, man has attained not only a new ground for humility of spirit but also a new ground for optimism and for belief in his own supreme importance, since the forces which control his destiny have been placed very largely in his own hands.

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## THE MANAGEMENT OF A CHILD WELFARE WEEK IN SMALL CITIES AND TOWNS WITH RESULTS*

MARY POWER, TORONTO.

In November, 1917, the Child Welfare Exhibit started upon a tour of the cities in the western section of the province in the following order: Brantford, Woodstock, Kitchener, Galt, and Guelph. On February 11th, a Child Welfare Week was held in the City of London, followed by a tour covering Windsor, Tillsonburg, Welland, Niagara Falls, and St. Catharines. Chatham was not visited because of an epidemic of smallpox present at the time. A third tour was made in the month of April, when Whitby, Oshawa and Port Hope were visited. The time for which the exhibit was shown varied from one week in London to one day in Port Hope.

For exhibit purposes it may be said that there are two classes of towns: (*a*) Those in which Child Welfare work is being carried on, in which case the workers can be depended upon to arrange for a local committee. (*b*) Communities in which there is no Child Welfare work being done, which neces-

*Read at the annual meeting of the Canadian Public Health Association, Hamilton, May 27th and 28th, 1918.

sitates an endeavor on our part to have representatives from various organizations appointed and a local committee thus formed. We have worked with committees brought together by (1) Medical Officer of Health, (2) Children's Aid Society, (3) Victorian Order of Nurses. The policy of the Board has always been that of co-operation, and we have been fairly successful in that the Committees have been quite representative. We have always endeavored to enlist the interest and co-operation of hospitals, local Medical Society, local Board of Health, Children's Aid Society, Schools, Philanthropic and Nursing Agencies, Women's Organizations (Women's Institutes), Daughters of the Empire, the Local Council of Women, etc., and Patriotic Associations.

The work done during the time the Exhibit was shown consisted of: holding of a baby clinic, to which mothers were invited to bring their infants and children of pre-school age. The moving pictures of the Provincial Board of Health are shown at any time during the day or evening convenient to the local committee. The exhibit of the Board, together with local exhibits, which as a rule comprise those of Local Board of Health, hospitals, schools, etc., are demonstrated throughout the day and evening. Results: To fully sum up the results of exhibit work is impossible, but we can point with satisfaction to (1) The formation of a permanent Child Welfare Association in London, which has since established weekly baby clinics in both public hospitals in that city. (2) The establishment of baby clinics in Port Hope, the maintenance of which has been very happily arranged for by co-operation of the hospital, its nurses, and medical staff. In passing, it may be noted that by distribution of work among the local medical men, it will be necessary for each to act only once in six weeks. (3) We have reasonable hope that clinics will be established in Windsor, Brantford, Galt, St. Catharines and Oshawa. In addition to these specific points, we may add that the comments of the mothers in every centre in which the exhibit was shown expressed appreciation for advice given and almost invariably a wish for a regular service in their own city.

With the splendid organization of the Women's Institutes in the rural sections of the province and certain associations on the urban centres, the Bureau hopes to be able to accomplish much through the medium of the Child Welfare Exhibit in the reduction of infant mortality in the province.

# Editorials

## THE ONTARIO MEDICAL COUNCIL

We are told by one of the daily papers of Toronto, June 29th, that the Ontario License Board is endeavoring, through the license vendors, to keep track of the liquor requisitions furnished by doctors. This is quite right, as will generally be conceded.

The Commissioners, we understand, are not satisfied with the manner in which the Medical Council dealt with the prescription question, particularly in one case. The Chairman, Mr. J. D. Flavelle, is reported to have said: "It would have been great moral assistance to this Board if the Council had taken more drastic action in this —— case. If it is the case, as is reported, that Dr. ——'s name cannot be removed from the list until next June, it looks to me like side-stepping responsibility." The Vice-Chairman, Mr. Dingman, said: "There could not have been a grosser case for them to deal with." The Medical Council may not always do exactly the right thing, but we happen to know that it is the unanimous wish of that body to have the doctors throughout the province comply with the law when giving orders for alcohol in any form.

We cannot discuss the matter in detail, but we happen to know both Mr. Flavelle and Mr. Dingman, and we can state very positively that they are fair-minded and reasonable men. If these two had been members of the Council when this matter was discussed they would both have acted as did the mem-

bers present. Under such circumstances it is rather a pity that, with their imperfect knowledge, they should have publicly expressed any opinion in the matter.

## AMERICAN HOSPITALS IN ENGLAND

The accommodation for American wounded in England is constantly increasing. Near Southampton, Salisbury Court, a Military Hospital for 3,000 men is being erected. Around the Old Manor House there will be ten acres of huts. The ambulances which meet the hospital ships will carry the wounded to this beautifully situated institution. In London the Army Council have taken over the Southern and North-Eastern Hospitals of the Metropolitan Asylums Board for Americans. In Portsmouth the Council will take over the Municipal Hospital for the same purpose.

## THE GENERAL ELECTION IN GREAT BRITAIN

It is expected that there will be a general election in Great Britain in the near future. We are told by the *British Medical Journal* that the agents and organizers of the old parties are perplexed, and only the new labor party appears to know its own mind.

For many years people in that country have wondered why there were not more medical men in the House of Commons. It is thought that an increase in such membership would be in the interests of the public and also of the profession itself. The *Journal* thinks that the executive officers of the division of the

British Medical Association should look into the matter as soon as possible. It is thought that many of the Universities of the United Kingdom might be induced to elect a certain proportion of medical men. At present the number of representatives from Universities is seven. In the next Parliament there will be thirteen.

Already there are some medical candidates in view. Sir William Whitlaw will be a candidate for Queen's University, Belfast. For the three seats of Scottish Universities there will probably be four new medical candidates, and it is hoped that Sir Watson Cheyne, now a member for Edinburgh and St. Andrew's, will be a candidate again. The University of London has no candidate, but the medical profession feels grateful for the services rendered to it in the present Parliament by Sir Philip Magnus, a sitting member. The *Journal* points out that Cambridge has not infrequently elected a man of science, while Oxford seems generally to have looked for political eminence already achieved.

# News Items

The annual meeting of the Association of Anatomists will be held in New York, December, 1918.

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The next meeting of the Southern Medical Association will be held at Ashville, N.C., November 11th to 14th.

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The next meeting of the Southern Surgical Association will be held in Baltimore, Md., December 17th to 19th.

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The next meeting of the American Public Health Association will be held in Chicago, October 14 to 17, under the Presidency of Dr. C. J. Hastings, M.O.H., Toronto.

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The annual meeting of the Association of American Railway Surgeons will be held in Chicago while the Public Health Association is in session, October 16th to 18th.

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The Winnipeg General Hospital is asking the city for $90,000 to meet urgent expenses.

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The Province of Alberta appropriated in July $218,000 for hospital purposes in that province during the present year.

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The Hospital Unit from Saskatchewan and Alberta, is now stationed in Lorraine, France.

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An up-to-date hospital is being built at Kannaskis, near Banff, Alberta. The cost will be about $400,000, of which the Dominion and the Province will each pay half. It will accommodate 300 patients.

It is stated that up to June 1, 1918, the Canadian Pensions Board had awarded 35,000 pensions and 3,000 gratuities.

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Canada has been divided into sections for the purpose of the Invalided Soldiers' Commission.

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The McLaughlin Company, Oshawa, Ontario, have donated a maternity hospital to that town, to be called The Llewellyn Maternity Hospital.

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A large proportion of the medical students on duty overseas have obtained leave to return to their colleges for the coming winter session.

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The wards in the Isolation Hospital, Toronto, are no longer free. The rates now are: public wards, $1.25; semi-private, $2.00; and private wards, $3.00 a day.

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The Edith Cavell Home, within the London Hospital Grounds (Eng.), was formally opened in July. The bust of Miss Cavell, which has been placed in the East Room of the Home, was unveiled on that occasion.

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The many practitioners who have done post-graduate work in St. Thomas Hospital, England, will be interested in learning that 1,050 old students and 60 of the staff of that hospital have served in the war. Fifty-two have been killed and 100 have received honors and distinctions of various sorts.

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Dr. Chas. J. Hastings, M.O.H., Toronto, has asked the Local Board of Health to acquire more information regarding the prevalence of tuberculosis in this city. This will be done in conjunction with similar work done in other parts of Canada. Nine years ago there were six institutions in Canada caring for the tuberculous. There were then 350 beds. There are now nine hospitals with, altogether, about 3,000 beds. It cost then for maintenance about $150,000, and now it costs about $900,000.

His Majesty the King, during his recent trip in Flanders and France, visited the Canadian Hospital at Doullens. It will be remembered this was one of the hospitals bombed by the Huns a few months ago.

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The following were elected officers of the Manitoba Medical Association at the last annual meeting held in Winnipeg: President, Dr. Shortreed, Grand View; Vice-Presidents, Drs. G. Cansell and H. D. McCalman, Winnipeg; Secretary, Dr. Hugh McKay, and Treasurer, Dr. Sydney Pierce, both of Winnipeg.

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The following have been appointed Assistant Medical Directors: Maritime Provinces, Maj. Dugald Stewart, Bridgewater, N.S.; Ontario, Capt. Edward Ryan, Kingston, Ontario; Manitoba, Maj. Norman McIvor, Winnipeg, Man.; Saskatchewan, Capt. W. C. Arnold, Regina; Alberta, Maj. D. R. Johnson, Edmonton; British Columbia, Maj. Arthur Proctor, Vancouver, B.C.

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Lt.-Col. Casgrain, of Windsor, Ontario, after a leave of two months spent in England, is back at the Hospital of St. Cloud, of which he is O.C. This hospital was given by the Canadian Government for the treatment of French soldiers. The French Government supplied most of the huts while the Canadian Government furnished them. Each hut has 28 beds, and is named after some province or city of Canada. About 60 per cent. of the medical and surgical staff are French Canadians.

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The following appointments have recently been made:—Lt.-Col. T. R. Caldwell, C.A.M.C., to be O.C. Bourley Segregation Camp; Lt.-Col. Percy Goldsmith, C.A.M.C., O.C. 15th Canadian General Hospital; Major D. J. Huggings, O.C. Canadian Musketry Camp; Major W. Macaw to be instructor Canadian Army Gymnastic Staff; Capt. H. E. Sturdea, member of Staff of the Granville Special Hospital, Buxton; Lt. D. Robertson on the Staff of the Westcliffe Eye and Ear Hospital, Folkestone.

The following officers were elected at the Annual Meeting of the Medical Council of Canada, held at Ottawa in June last: Honorary President, Sir Thomas Roddick (re-elected); President, Dr. Eden Walker, New Westminster, B.C.; Vice-President, Dr. J. C. Connell, Kingston; Registrar, Dr. R. W. Powell, Ottawa (re-elected).

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Dr. McCullough, C.O.H., Ontario, inspected the Military Camp at Niagara, Sept. 25th. He found there had been something like 200 cases of influenza resembling that form which is called Spanish influenza in some quarters. Since the above was written Dr. McCullough has issued a circular letter to the profession of the province. From it we extract as follows:

Investigations carried on by the Canadian Army Medical Corps overseas have developed the fact that the so-called Spanish Influenza has a different causation from that of the ordinary La Grippe of 1889, and which is due to the Bacillus Influenzæ commonly called Pfeiffer's bacillus.

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Dr. J. M. Johnston, of Elm Street, Toronto, who was convicted of performing an illegal operation in March last, was sentenced to confinement for two years in the Burwash Jail. Dr. Johnston is 63 years of age, graduated from Trinity University in 1882 and practised medicine at 35 Elm Street for over thirty years. One remarkable feature in this case is the fact that Dr. Johnston is and has been for many years a comparatively wealthy man. He amassed his wealth in a perfectly legitimate way by saving his earnings, and investing from time to time in city property. It was stated in one of the daily papers in Toronto that last year his income was something like $20,000, apart from what he earned in practice.

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During this season, and especially the early summer, there was an epidemic of influenza both in Europe and North America. For a time it was the fashion to describe the disease as Spanish Influenza, but there seems to have been no reason for the introduction of the adjective Spanish. It was perhaps more universally prevalent in Germany than in any other country. The symptoms were really similar to those of an influenza epidemic during the last several years, and included fever, general aches.

irritation of the conjunctival, nasal and mucous membranes. The disease runs its course in a few days, and has not this year been attended by serious consequences.

Nearly all physicians who have practised for thirty years or more will remember the very serious epidemic of what was then called La Grippe, in 1889-1890. For a time it was called Russian Influenza, but we doubt if there was any more reason then for the word Russian than there is this year for the word Spanish.

Clinically the disease simulates influenza. It is an acute febrile infectious condition of three or four days' duration. The most striking symptoms are: Sudden onset with chills, severe headache with pain in cervical, dorsal, and lumbar regions, also pain in limbs and general malaise.

We learn from Dr. F. C. Harrison that, at the time of writing, Sept. 29th, a number of men of the Flying Corps have contracted the disease, a large number of them being in the Base Hospital, Toronto.

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The following letter gives definite information regarding the splitting of fees in one portion of Ontario:

"Tanlon, Ontario, Sept. 3, 1918.

"Dr. A. B. Carver, Surgeon,
Toronto.

Dear Doctor:

I am writing you re the B. B. Hiscon case, of Tanlon, on whom you operated August 16th.

The physicians in this part of Ontario receive a percentage of the surgeon's charge, which is understood among them.

Mr. Hiscon being my patient, the percentage of your charge would come to me. The percentage in this locality is from 25 per cent. to 33 1-3 per cent. when the surgeon comes to town, and 50 per cent. when the patient is sent to the surgeon.

Kindly let me know what your usual custom is in this matter.

Respectfully,
(Sgd.) J. B. Curshon."

(Names only have been changed. Carver, Curshon, and Tanlon represent a surgeon of Toronto, a physician, and a village of Western Ontario, respectively).

# Personals

Col. Murray MacLaren has been appointed O.C. Granville Hospital, Buxton.

Rev. R. B. Nevitt, son of Dr. Barrington Nevitt, of Toronto, died at Margate, England, August 15th.

Dr. (Lt.-Col.) Harold Parsons is now working with the committee which is inspecting Canadian military hospitals.

Among those going to Siberia are Drs. Fred A. Cleland, W. A. Warren, F. J. Colling and W. W. Morrison.

Dr. Allen Baines returned to his home, Toronto, Sept. 24, after a trip to the Pacific Coast.

Among those going to Basingstoke are Drs. Norman McLaurin, C. F. Clark, Hanna, Oliver Maybee and Robinson.

Capt. Smith, son of Dr. (Major) Harley Smith, of Toronto, was killed in action while fighting in France with the French troops.

Dr. F. N. G. Starr, of Toronto, arrived in England, Sept. 25, and is now with the R.A.M.C. as one of the consulting surgeons.

Lt. J. McFaul, son of Dr. J. H. McFaul, 474 Dovercourt Road, Toronto, was reported missing July 10th, and was unofficially reported dead September 9th.

Capt. Bryan Melville Loudon, son of the late Dr. James Loudon, President of the University of Toronto, and brother of Dr. Julian Loudon, was reported killed September 12th.

Dr. Gibb Wishart had a sudden attack of serious illness at Georgian Bay, Sept. 24. Dr. R. B. Nevitt happened, fortunately, to be near at hand, and at once brought the patient to the General Hospital, Toronto.

It is stated that Col. Lorne Drum, who was recently A.D.M.S. of Division 5, has been appointed O.C. of McGill Hospital Unit.

Dr. H. L. Abrahamson, who has done much work in connection with infantile paralysis, has been placed in charge of the Provincial Laboratory in St. John, N.B.

Col. J. M. Elder, M.D., of Montreal, was recently appointed a consulting surgeon in the area of Rouen under the R.A.M.C. Many in Montreal think that Dr. Elder's able work as surgeon should have received proper consideration from the military authorities some time before.

Dr. Hastings, Medical Officer of Health, Toronto, has found rather large quantities of the colon bacilli in some of the swimming tanks of the city. In future the water in these tanks must be chlorinated and filtered, and all visitors must present medical certificates of health before entering the baths.

Dr. Jack Orr, of Chicago, spent a portion of the summer with his brother, Dr. R. B. Orr, at the summer home of the latter on the Georgian Bay. He has returned to Toronto, where he will remain only a short time, and then go down to Miamy, Florida, where he spent the winter last year. He thinks from a health standpoint that Florida is preferable to California.

Dr. Jno. W. S. McCullough was requested to take charge of the Medical Unit going to Siberia, but the Government preferred to have him remain in Toronto. We are inclined to think that under the circumstances Dr. McCullough at the present time can do more good in working for Ontario in the city of Toronto than he could in Siberia.

# Obituary

## WALTER NORMAN BROWN, M.D.

Dr W. N. Brown, of 375 Spadina Road, Toronto, and formerly of Roseneath, Ontario, died at his home, August 30th.

## HENRY WALKER, M.D.

Dr. Henry Walker, of Wetaskiwin, Alta., died at Kamloops, B.C., July 25th. He was born in Ingersoll, Ontario, and received his medical degree at the University of Toronto in 1903.

## E. P. LACHAPELLE, M.D., LL.D.

The late Dr. Lachapelle, of Montreal, was for many years the greatest and best beloved among French-Canadian doctors. He enjoyed his usual good health up to a few months ago, when symptoms of cholecystitis appeared. On the advice of friends he went to Rochester, where he was for some time under the care of Dr. Charles Mayo. An operation was performed, after which he apparently rallied for a few days, but during the hot wave he suddenly got worse, and died within a short time, in his 73rd year.

Early in his professional career he paid special attention to hygiene, and shortly after graduating was appointed Professor of Hygiene in Laval University. His professional activities were many. He was elected in 1878 as a Governor of the Medical Council of Quebec. He was a prominent member of the Dominion Medical Council. Illness prevented him from attending the last meeting of that body in June, when, if well, he would have sat as president. He was for many years Dean of the Medical Faculty of Laval University.

During his long and honorable career he filled many other offices in connection with various medical societies to which he belonged. There can be no doubt of the fact that Dr. Lachapelle

was one of the greatest of our Canadian citizens. He had travelled much, observed much, read much, and with his breadth of mind and courteous manners he was both respected and beloved by all who knew him.

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## EMMA JONES CULLEN

We announce with deep regret the death of Emma Jones Beckwith, the wife of Dr. Thomas Stephen Cullen, of the Johns Hopkins University, Baltimore, Md., which occurred after a long and painful illness from exophthalmic goitre, September 14th.

The city of Toronto claims Dr. Cullen as one of its own family, and many of us sympathized with the work of his earlier years, rejoiced with him in his prosperity, and now mourn with him in his adversity. Although born in Bridgewater, Ontario, he spent most of his boyhood days in Toronto, and was educated at the Collegiate Institute and the University of Toronto. After considerable post-graduate work in Baltimore and Germany, he became attached to the Gynæcological Staff in Johns Hopkins, and although tempted to leave there at times he is still on the staff of that hospital. It is perhaps not generally known that he declined the Chair of Gynæcology which was offered to him by Yale in 1900. He was married in 1901 to Miss Emma Beckwith, of Williamstown, Mass.

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Donald Chisholm McDonnell, a young druggist, of Toronto, and son of the late Dr. A. R. McDonnell, of Orillia, was killed in action August 16th.

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Mr. Norman Macpherson Clark, only son of Dr. A. M. Clark, Woodstock, Ontario, was killed in action on August 28th, aged 26.

# Book Reviews

The United States Government, through the Council of National Defence, are issuing a series of medical war manuals. They are concise, and all written by specialists. We have before us Nos. 3, 5, 6, 7. Authorized by the Secretary of War, and under the supervision of the Surgeon-General and the Council of National Defence.

*Medical War Manual No. 3: Military Ophthalmic Surgery.* By Allen Greenwood, M.D., Major, M.R.C., U.S.A. Recently Honorary Lieut.-Colonel, Harvard Surgical Unit with the Royal Army Medical Corps, British Expeditionary Force. Including a chapter on Trachoma and other Contagious Conjunctival Diseases, by G. E. de Schweinitz, M.D., Major, M.R.C., U.S.A.; and a chapter on Ocular Malingering by Walter R. Parker, M.D., Major, M.R.C., U.S.A. Illustrated. Philadelphia. Lea & Febiger. 1917.

*Medical Manual No. 5: Lessons from the Enemy—How Germany Cares for Her War Disabled.* By John R. McDill, M.D., F.A.C.S., Major, Medical Reserve Corps, U.S.A. Illustrated. Philadelphia: Lea & Febiger. 1918.

*Medical War Manual No. 6: Laboratory Methods of the United States Army.* Compiled by the Division of Infectious Diseases and Laboratories, Office of the Surgeon-General, War Department, Washington, D.C. Illustrated. Philadelphia and New York: Lea & Febiger. 1918.

*Medical War Manual No. 7: Military Surgery of the Zone of the Advance.* By George de Tarnowsky, M.D., F.A.C.S., Surgeon to Cook County and Ravenswood Hospitals, Chicago, Major, M.C., U.S.A., American Expeditionary Force, France, 1917-1918. Illustrated. Philadelphia and New York: Lea & Febiger. 1918.

It is really impossible to review these many volumes individually, as the material is so profuse and concise and the subject matter itself put in such brief space that review is almost impossible without quoting the book. The material matter is

all up-to-date, in fact far ahead of anything else that we have at the present time. As to treatment of wounds, the conditions dealt with by the eye specialists and the laboratory methods used by the Americans are all of the most advanced. We can only say these volumes, in fact the whole series, should be at the command of every officer of the military corps. The subject material is always dealt with from the Allied position and usage and can be relied upon as being the latest method of treatment.

The volume dealing with "Lessons from the Enemy" is most replete and shows some points of great interest, and some points which it would be very advantageous for us to adopt.

The publishers are to be congratulated in undertaking this series of War Manuals, and we are looking forward to other volumes to follow.

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*Medical Service at the Front.* By Lieut.-Col. John McCombe, C.A.M.C., and Capt. A. F. Menzies, M.C., C.A.M.C. Illustrated. Philadelphia: Lea & Febiger, publishers; 1918.

The above is an exceedingly interesting record of the work done by the Army Medical Corps. The authors are Canadians who have done exceedingly fine work at the Front, have seen and observed carefully the treatments of injuries from the front line to the base hospitals. They describe the situation from the trench to the base with diagrams so that it is simplicity itself to understand the complex arrangements and duties of the different officers as clearly defined, and we can easily point to this as one book that all members of the C.A.M.C. should be possessed of. In fact, in our opinion, it would be a wise investment for the Department of Militia and Defence to give a copy of this book to each medical officer in the Army Medical Corps.

# Selections

### The Use of the Longitudinal Sinus for Diagnosis and Treatment

At the recent meeting of the Section on Diseases of Children of the American Medical Association, Fischer presented a paper on this subject which may be summarized as follows:

The anatomical position of the longitudinal sinus beneath the anterior fontanel renders it very accessible in an infant up to the end of the second year. Its large size is another factor which aids in giving an infant the benefit of diagnostic and therapeutic measures which otherwise are difficult to obtain.

By the use of this sinus we have a direct channel through which a large or small quantity of blood can rapidly be taken from, or added to, the circulation. Since time counts a great deal in depleted and marasmic infants, the simpler the route the more advantageous to the infant.

Many obscure conditions exist in which intestinal intoxication and faulty metabolism of the food elements is diagnosed. Before a positive diagnosis can be made, if a luetic basis is suspected, a Wassermann or Noguchi reaction may be required.

The longitudinal sinus is also adapted for the abstraction of blood, as in venesection during convulsions. The relief afforded by this means is rapid and does not produce shock. Intracranial pressure can be relieved quickly, and this method of local depletion serves as well as a lumbar puncture. It is a most convenient place to give salvarsan injections. In septic diphtheria where rapidity of action is necessary to bring the antitoxin into the circulation, the sinus route is indicated.

In hæmophilia, Peterson reports six transfused cases, one of these through the sinus route, with excellent results. As a hæmostatic human blood acts in many instances rapidly—almost as a specific. In a hæmophilic infant following circumcision, two ounces of blood injected into the sinus checked the hæmorrhage within twenty minutes, although the infant had bled for four hours prior to this treatment. In another case of continued hæmorrhage following an excision of cervical glands, postoperative treatment was unavailing until one ounce of human blood was injected by the sinus route.

Dextrose solution may be injected by this route. Sodium

bicarbonate solution may also be injected in cases of acidosis. Normal saline solution and sterile serums may be injected during, or following, atrophic conditions due to enterocolitis. Such injections may be repeated once in twenty-four hours without producing shock. The first injection of 100 cubic centimeters may be followed by one of 150 cubic centimeters, and later 250 cubic centimeters may be injected every twenty-four hours until good stimulation is produced.

The shock incident to the exposure of a vein and the loss of time are factors which one must bear in mind when an easier, safer, and more rapid method offers itself. The risk of infection if one exposes the jugular, femoral, or median basilic vein must not be overlooked, especially in the weakened and puny infant.

*Technique.*—The infant should be wrapped in a mummy bandage, well pinned so that the arms and legs are confined, and placed flat on its back on a table. The head should be steadied on both sides by an assistant while the needle is inserted into the sinus. Anatomically the sinus does not vary. It grows wider toward the back of the head, hence we should always utilize a point as far posteriorly as possible. As the needle is pushed through the posterior angle of the fontanel it should be directed downward and backward in line with the sagittal suture. The landmarks are positive, and with but little practice we cannot fail to enter the sinus.

As the sinus lies very superficially we need not go deeper than 1 or 2 millimeters. For this purpose a needle one-half inch long of a 20 to 22 gauge, with a sharp point, is best adapted. For withdrawing blood a Luer or Record syringe should be attached. As the needle penetrates the sinus resistance is lessened, and we encounter the same sensation which we feel when the needle pierces the dura in doing a lumbar puncture.

We are now ready to aspirate sufficient blood for diagnostic purposes, or to transfuse the required quantity of blood or medication. As there is negative pressure within the sinus, before injection, it is better to withdraw blood, thus making sure we are actually in the sinus. The fluid is best given by gravity. A cylinder with a capacity of 30 to 100 cubic centimeters may be used. One end of a piece of rubber tubing is attached to the cylinder, and the other end has a connecting tip which fits into the needle. It is of advantage to have a stopcock either at the end of the cylinder or near the end of

the tubing. The needle is inserted with a small syringe attached. By slight aspiration one can determine whether the sinus has been entered; if so, the syringe is detached, and the apparatus, which has been filled, and the air expelled, is connected. Air-pressure in the tube should be released by detaching the syringe before the needle is withdrawn.—*Therapeutic Gazette.*

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**Cardiac Hypertrophy in Aviators**

In the course of a series of X-ray examinations Etienne and Lamy have found evidence that hypertrophy of the left ventricle is constantly present in aviators after five months' flying, and that this hypertrophy develops in two phases—the first of rapid growth so that appreciable enlargement occurs in the course of some months, and a second slowly progressive increase, shown by the outline of the left ventricle, which brings the apex close to the nipple line, even in men who have been flying for two or three years. The hypertrophy is proportional to the altitude at which the aviator usually flies, being more marked in those accustomed to an elevation of 15,000 ft. than in those usually flying between 3,000 and 9,000 ft. It would appear to persist, for it was still very noticeable in a man who had left flying for more than eight months. Dilatation of the right ventricle was only found in one instance, and then in association with hypertrophy quite out of proportion to the elevation at which the aviator had usually flown. For a long time there are no symptoms nor any functional disturbance. The hypertrophy is seen both in those whose previous life was sedentary and in those devoted to athletics, and appears to be a physiological adaptation to the constantly changing conditions during aviation. Thus the systolic blood pressure rises after the aviator reaches an elevation of 7,500 ft., and falls after the flight; the fall may be as much as 20 mm. of mercury when the descent has been from a height of 15,000 or 18,000 ft. The diastolic pressure falls during the flight, and after the flight rises 5 to 10 mm. or more when the descent has been rapid. The cardiac hypertrophy may be due to the rise in the systolic and diastolic pressure, but possibly repeated phases of sudden low pressure may also play a part. In support of this rather unlikely explanation it is stated that experimental rabbits, allowed to live for six months after repeated intravenous injections of the depressor bases of the urine, had enormously hypertrophied hearts,

which indeed were much larger than those seen in rabbits injected with adrenalin or the pressor bases of the urine. It is probable that the frequency of the blood pressure changes is more important than the actual rise or fall in causing the cardiac hypertrophy; as Ferry has pointed out, the organism of the aviator when in the air is constantly attempting to maintain a condition of circulatory equilibrium whch, however, is always elusively escaping from control.—*British Medical Journal.*

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### The Small Heart in Tuberculous Subjects

Frequent observations on patients sent for radiological examination for the diagnosis of tuberculosis have enabled Dr. Carlo Guarini to collect a large number of cases of the small median heart which is said to be characteristic of tuberculous or pre-tuberculous patients. Rokitanski was one of the first to draw attention to the small size of the heart, which he considered congenital and a sign of infantilism, and Albert-Weil more recently described it as a frequent occurrence in individuals who were tuberculous or predisposed to tuberculosis. Barjon also noticed that the tuberculous were habitually the subjects of a median heart which overlapped only to a small extent, to right and left, the central shadow. According to this observer, the median heart is indicative, if not of tuberculosis, at least of a predisposition to it, while, on the contrary, the existence of a large heart in an individual suspected of pulmonary tubercle is of favorable interpretation. Vaquez and Bordet drew attention to the small, narrow heart suspended from a long aorta, the so-called "dropping heart" (*cuore a goccia*), which, however, they regarded as a physiological variety and having no pathological significance, arguing that if it be true that a small vertical heart is often found in tuberculous patients it is due rather to the peculiar formation of their thorax than to the pulmonary tuberculosis itself. Dr. Guarini's observations throw some light on these different views and tend to show that the small heart and the dropping heart are pathological entities in close dependence on the hypo-evolution of the other organs of the individual and on the hypoplasia of its anatomical parts. Of 1,300 tuberculous patients subjected to radiological examination he found the small median heart in 68 per cent. of the cases, whereas the dropping heart was only found in 0.13 per cent. He considers that the former is

a hypoplasic heart, while the latter, also hypoplasic, is due to an arrest of development of the heart and aorta during extra-uterine life; that both these varieties must be considered pathological entities, having no relation with the atrophic heart found in other morbid conditions, and that their presence is a far more reliable aid than clinical symptoms in the diagnosis and prognosis of tuberculosis. Few practical physicians are likely to take this view. Dr. Guarini has also made observations on the inclination of the heart's axis in the same class of patients. The older anatomists and clinicians fixed this inclination between 55 and 60 degrees; but Moreau, from radiological investigations on 100 normal adolescents and adults, found that in 74 per cent. the inclination varied between 65 and 78 degrees. Dr. Guarini found in 100 patients examined for diseases of the chest the inclination was in 6 per cent. between 20 and 30 degrees, in 37 per cent. between 30 and 40 degrees, in 41 per cent. between 40 and 50 degrees, and in 16 per cent. between 50 and 60 degrees. Thus the angle of inclination varied with the individual, or rather with the morphological constitution of the individual, between 20 and 60 degrees, which may be considered the extreme limits in tuberculous or pre-tuberculous subjects. It should be noted, however, that there may be small hearts whose axis of inclination exceeds the above limits, and these must also be considered pathological, since they represent hearts with incompetent valves or stenotic orifices. —*The Lancet.*

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**A New Empyema Technique**

Surgical drainage is carried out whenever possible from the most dependent part of a body cavity, but in the case of empyema it is often by no means easy to determine by physical signs the site for incision in order to have gravity entirely in favor of the operator. In the *Military Surgeon* for July, First Lieutenant Thomas R. Sealy, M.R.C., suggests a simple and ingenious technique for discovering the size and shape of an empyema before operation. Having aspirated what pus he can and accurately measured the volume drawn off, he injects through the not-withdrawn needle an exactly equal volume of a mixture of saturated boric lotion with an equal part of mucilage of acacia containing 10 per cent. of barium sulphate or carbonate in suspension. The patient is then at once X-rayed, the outline of the empyema is defined, and the chest opened at

what is now definitely known to be the most dependent point. In actual practice we believe that several considerations may limit the value of this procedure. In the first place, patients with empyema lie in bed, and the part of the pleural cavity most dependent in the erect position will not be so in the recumbent. Then the empyema patient generally lies on the affected side in order to give the healthy lung more play, making drainage easy wherever the opening is situated. Further, it must not be forgotten that when the cavity of an empyema has been emptied the space left is filled in part by the expansion of the lung, in part, especially in children, by the falling in of the chest wall, and in part by the rising of the diaphragm. An opening made at the most dependent part of the pleura may soon become blocked by the ascent of the diaphragm. Surgeons will, however, find it worth while to bear in mind Lieutenant Sealy's plan.—*The Lancet.*

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### Potassium Permanganate and Colloidal Manganese in Gonorrhoeal Sepsis

S. Mélamet (*Bull. Acad. Méd.*) believing that the antigonococcic action of potassium permanganate is due to its manganese content, has tried intramuscular injections of this salt and of colloidal manganese in 72 cases, with successful results in 65 cases. Three permanganate solutions were used, containing respectively 1.66, 2, and 2.66 mgm. in one ml. of distilled water. In acute urethritis, daily injections were made into the buttock, beginning with one ml. of the first solution, increasing by one ml. every three days to 5 ml.; next 2 ml. of the second solution was given for three days, increasing to 5 ml.; finally the third solution was used, stopping at the 3 ml. dose. Colloidal treatment consisted in daily injection of the contents of an ampoule of electric colloidal manganese. In most cases the injections caused localized burning, which usually passed off in five or ten minutes. No urethral treatment was used.—*The Prescriber.*

# Caffeinized Children

Among the true causes of delinquency in school children may be included caffein—the drug in coffee. Coughlin—*"Use and Abuse of Coffee,"* quotes a case :

> " Girl nine years old could not learn at school because of supposed dullness; could not see the black-board; was extremely nervous and confused. Drank a cup of coffee after each meal—three a day. On leaving off coffee, all symptoms gradually subsided, and the patient gained 8 pounds the first month. Complete recovery resulted."

There are still parents who do not realize the harm done to children by giving them coffee, as in the above typical case.

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P.—4

# Miscellaneous

### The Drug Supply After Four Years of War

This country has depended upon overseas sources for its supply of most of the important vegetable drugs before the war; and before the war the whole world drew practically all it needed in the way of the so-called "newer remedies" from Germany. But when need drives we can do without Germany. It is true that all drugs are relatively scarce and many of them very costly at the present time, but among the thousand and one materials inside and outside the Pharmacopœia those which are absolutely unprocurable can be counted on the fingers of one hand, while it is perhaps safe to say that not a single essential drug has entirely vanished from the shelves of our chemists' shops—a tribute to the power of our navy. When the market sections of the drug papers speak of a drug as being scarce it must not necessarily be inferred that the drug is being produced only in small quantities; the accurate inference is that the quantity available for distribution through the druggists to the civil population is greatly reduced, for we must remember that the demand for drugs from the medical services of our own and our allies' armies has to be met first. This is a not unimportant point, and we draw attention to it in order to emphasize the fact that when a drug is reported to be scarce it does not mean that sick and wounded soldiers lack the proper remedial agents. Then, again, it is common knowledge that glycerine is difficult to obtain and that castor oil of the best quality cannot be bought in the open market. But there is no intrinsic scarcity of either of these substances; they are being produced in quantities far exceeding the pre-war output, but the whole of the production is required for purposes other than those medicinal. Thus, taking a broad view, we have much to be thankful for. Notwithstanding the U-boats, trading vessels are bringing to port those vegetable drugs that cannot be produced in our soil and climate, and though freights are amazingly high, cargoes much reduced in weight, and ships less frequent and longer in passage, the storehouse is never empty. If there is no Turkish opium to be had there is a sufficiency of Persian; if we do not import quinine from Germany we can secure a goodly proportion of the product of the Dutch factories, or we can make quinine here from the cinchona bark of Java.

# Appointments as Medical Examiners

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This company was in fact founded to grant life insurance to persons below the average standard of fitness imposed by the ordinary life offices of that day. By its Act of Incorporation, eight of the Board of Directors must always be members of the Medical Profession. The long list of eminent physicians and surgeons who have served in this capacity is a recital of the leaders of the medical profession in Great Britain during nearly a century. Sir Richard Douglas Powell, (Bt., K.C.V.O., M.D., Physician in Ordinary to H. M. the King), is the present Vice-President of the Society.

It is upon the broad lines which this great company has proved scientifically and commercially successful, that the Empire Life Insurance Company of Canada purposes to proceed, and thus extend in the Dominion the protection of life insurance to a large class from whom it has hitherto been withheld.

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The keeping up of a regular supply of synthetic products presents a wholly different problem. Germany had, as everybody knows, secured a practical monopoly of the dye industry, and the synthetic production of drugs was an offshoot of that industry. When war broke out nobody foresaw how long it would last, and nobody appears to have begun at once to make preparations to produce synthetic drugs on a scale adequate to supply the country's needs in the event of a long war. The American chemists were not hampered like our own manufacturers were, and they got to work before us. But the necessity of establishing a fine chemical industry in this country was recognized in due course, and, after the initial problems had been solved, our chemists were able to produce some of the more commonly prescribed compounds in commercial quantities. In France, Spain, Holland, Japan, and especially in Switzerland, and even in some of our own overseas dominions, the drug industry has now been established. The result is that the world has been able to make itself independent of Germany; and if it can do this in war time we may be sure that it will be able to do it when labor becomes plentiful and the scarcity of raw materials is no longer a factor to be reckoned with. In his altogether admirable address at the Fifty-fifth Annual Meeting of the British Pharmaceutical Conference, Mr. C. A. Hill, the President, mentioned salicylic acid, aspirin, phenacetin, hexamine, and saccharin as substances which are being produced here on a regular scale. He did not extend the list further, but he did something more reassuring, for he said flatly, that "whenever a particular substance has been required for a particular purpose, British chemical science plus British chemical industry have not failed to produce it in requisite amount and of requisite purity within a reasonable time." Now all this is true enough, but it is important, in view of the future, to add Mr. Hill's proviso that, "questions of cost apart, the thing can be done." Lord Balfour's Committee on Trade After the War recommended that during a specified period British manufacturing chemists should be given very generous protection, so as to encourage them to establish here the synthetic drug industry on a large and permanent basis. We hope that the "questions of cost" will not be too far "apart." This class of drug can and should be produced here at a price which will allow of the products being sold for sums approximating to those which they would fetch if imported from abroad.

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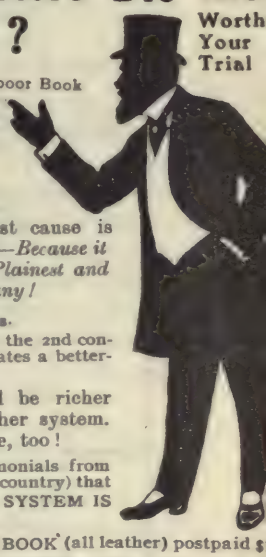

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mercial acumen of our manufacturers to believe that the public would not suffer unduly as a result of the protection recommended. The President of the British Pharmaceutical Conference in his address did not make the mistake of leading us to think that we had made any remarkable progress in the synthetic drug industry. We have made a good beginning, it is true, but the manufacture of some of the drugs mentioned has been, as he told the Conference, an industry *ad hoc*. Obviously this will not meet after-war conditions, for the production of synthetic drugs on an economical scale must necessarily be part and parcel of a large and general scheme. It is in the imaginative lay mind that the danger lies, and it is to be hoped that the Exhibition of British Scientific Products now being held at King's College will not have the effect of impressing the public with the belief that so far as the production of drugs is concerned our difficulties are over. Those behind the scenes will tell us that we are only at the beginning. Nevertheless, a good beginning has been made, and there is no reason why progress should not go on provided that the movement receives the whole-hearted support of the public and the assistance of the Government when the strife is at an end. It is clearly demonstrated that British manufacturers are thoroughly capable of supplying us with products of a quality as good as, if not better than, those hitherto supplied from foreign sources. Their patriotic enterprise deserves all the encouragement it is possible to give. Medical practitioners need not be reminded how intimate is the relationship of the manufacture of dye for stuffs to the production of these drugs; and it is to the great dye factories, rather than to the druggists, that we must look for the development of the industry. Before the war we visited some of the most important of the German dyestuffs factories; the visit impressed upon us the fact that a successful synthetic drug industry depends upon a successful dyestuffs industry.—*The Lancet.*

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### A Patient's Contra Account

The *South African Medical Record* tells a good story of a medical practitioner who, when visiting a regular patient, found he had forgotten to bring a lancet, which he required. He, very courteously, asked the father of the patient if he would mind fetching it from his house, which, by the way, was only just across a square. The father went, apparently with the

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greatest willingness, and fetched the lancet. In due course an account was sent in by the medico. A cheque came promptly, but with five shillings deducted, this contra entry in the doctor's account being explained as follows: "To visiting Dr. Blank's house at his request, for the purpose of procuring an instrument, 5s." The doctor at first thought of sending a legal demand for the odd 5s., but, on second thoughts, decided that as this patient—a German, by the way—valued his own time at 5s. a visit, he probably would not object to his doctor valuing his at a higher rate, so he resolved, in all future accounts, to increase his charges per visit to his house from 5s., which had hitherto been the figure, to 7s. 6d. The patient has regularly paid this higher charge without comment, and the parties continue on the best of terms.—*The Hospital.*

---

### Intellectuals and the War

The world is upside down, and it will take a long time for conditions to revert to normal. Indeed, such radical changes have been effected in so many directions that life will probably never again be the same. In the *Glasgow Herald* a few weeks ago there was an article dealing with the effect of army life upon the intellectuals. The writer argues that military service tends to intellectual atrophy, and believes that many of these men of brain and culture will be quite unable after the war to carry on the work in which they were formerly engaged. The first lesson the intellectual has to learn in the army is that of complete subservience of mental faculties. He has to reason, but to reason along stereotyped lines. He loses the independence of thought to such a degree that the reasoning becomes in the worst sense mechanical, which is intellectual stagnation and even death. The day of the soldier is filled with mechanical work, the mind atrophies, stimulation is lost, and intellectual interests are deprived of their grip. Physical exhaustion plays its part until the victory of matter over mind is complete. The craving for relief from the benumbing routine of work becomes intense and takes the form of an overpowering desire for sensuous pleasures. As a matter of fact, mental work is almost impossible among the surroundings of trench life and mental apathy supervenes. The entire system of army service is hostile to intellectual life and frowns upon any attempt to exercise the reasoning powers except within very narrow limits.

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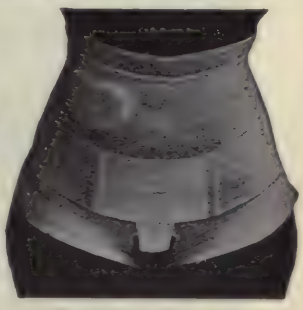

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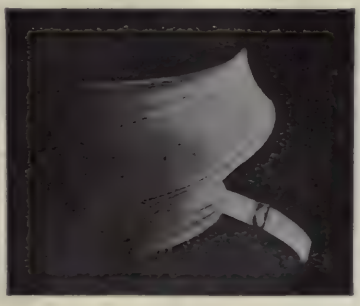

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If, then, military life is inimical to intellectual life and renders the reasoning faculties torpid, the question arises, Can men of brains who have been thus affected "come back"? The writer whose views we have quoted appears to be pessimistic regarding their ability to do so. He thinks that, as a rule, their powers of mind have been virtually killed or so greatly inhibited that they will require very careful treatment in order to be enabled to recover. They will have forgotten much that they knew and will have to begin over again to a large extent. Therefore, ambition must be revived in them and their minds must be stimulated to regain an interest in matters which have become alien to their thoughts. There may be a little truth in what the writer says, but he takes altogether too black a view of the intellectual who has fought in the war. Although he will never regard life with the same eyes as formerly, his mind will have been stimulated rather than blunted, and he will come back more of a man, mentally and spiritually, than he went in, and his views of life and its problems will be widened immensely.—*Medical Record.*

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**X-Rays in Treatment**

W. G. Harvey, in *Lancet,* gives his experience of the value of the X-rays as a therapeutic agent:—

Ringworm.—A fortnight after the proper dose the irradiated area sheds its hair, while three months later a new growth, free from the parasite, occurs. Care must be observed to avoid accidents, such as alopecia.

Favus.—Results theoretically are equally good, but such cases often become reinfected.

Epithelioma on a lupus site should never be treated with X-rays: the results are very bad.

Lupus does well, but the cosmetic results of Finsen light are probably better.

Lupus erythematosus is not benefited.

Tuberculous glands do not give satisfactory results.

Actinomycosis was not affected in one case.

Simple goitre was not benefited to any extent.

Malignant tumors, when inoperable, are frequently relieved and occasionally cured.

Uterine myomata and enlarged prostates require massive doses, but with such appear to do well.—*Prescriber.*

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**The Marvel Company was awarded the Gold Medal, Diploma and Certificate of Approbation by the Societe D'Hygiene de France, at Paris, Oct. 9, 1902.**

### Low Death Rate from Disease in the Army

According to a statement recently issued from the office of the Surgeon-General, a health rate which, as far as known, has never been surpassed, has been established by the American Armies both here and overseas. For the week ended July 26 the combined reports of the American Expeditionary Forces and of troops stationed in the United States show an annual death rate for disease of 1.9 per 1,000—less than 2 men per 1,000 per year. The annual death rate for disease of men of military age in civil life is 6.7 per 1,000. This new rate is based on an approximate strength of 2,500,000 men, and includes men living under abnormal conditions. The overseas record was made while American soldiers were participating in the heavy fighting in the Marne salient, when they were frequently compelled to sleep and eat under the most primitive conditions. That this record is truly representative of the general health of the troops is shown by the combined reports, which indicate the figure of 2.8 per 1,000 as the average death rate for disease during the past two months.—*Medical Record.*

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### Henley on Lister

Henley, who knew Lister in the early days of his professorship, drew the following picture of him in a sonnet entitled, "The Chief":—

"His brow spreads large and placid, and his eye
Is deep and bright with steady looks that still.
Soft lines of tranquil thought his face fulfil—
His face at once benign and proud and shy.
If envy scout, if ignorance deny
His faultless patience, his unyielding will,
Beautiful gentleness, and splendid skill,
Innumerable gratitudes reply.
His wise, rare smile is sweet with certainties,
And seems in all his patients to compel
Such love and faith as failures cannot quell.
We hold him for another Heracles,
Battling with custom, prejudice, disease,
At once the son of Zeus with Death and Hell."

—*The Prescriber.*

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PUT UP IN BOXES OF ONE HUNDRED CAPSULES EACH

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- Blaud (Duncan) - - 1 Pill
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- Blaud (Duncan) - 2 Pills
- Liq. Arsenicalis - - 2 Minims
- Strychnine - - 1/50 Grain

**No. 109**
- Blaud (Duncan) - - 3 Pills
- Liq. Arsenicalis - - - 2 Minims
- Strychnine - - - 1/50 Grain

These combinations are of *the Highest Value as a General Tonic,* and especially for the treatment of convalescents after fevers.

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### The Day

This poem was written by a railroad porter in England some two years ago. One of the popular toasts at military banquets in Germany used to be *Der Tag*—the day when Germany would make an actuality of another toast, *Deutschland über Alles.*

You boasted the Day, and you toasted the Day,
  And now the Day has come.
Blasphemer, braggart and coward all,
Little you reck of the numbing ball,
The blasting shell, or the " white arm's " fall,
  As they speed poor humans home.

You spied for the Day, you lied for the Day,
  And woke the Day's red spleen.
Monster, who asked God's aid Divine,
Then strewed his seas with the ghastly mine;
Not all the waters of the Rhine
  Can wash your foul hands clean.

You dreamed for the Day, and you schemed for the Day;
  Watch how the day will go.
Slayer of age and youth and prime
(Defenseless slain for never a crime).
You are steeped in blood as a hog in slime,
  False friend and cowardly foe.

You have sown for the Day, you have grown for the Day;
  Yours is the harvest red.
Can you hear the groans and the awful cries?
Can you see the heap of slain that lies,
And sightless, turned to the flame-split skies,
  The glassy eyes of the dead?

You have wronged for the Day, you have longed for the Day
  That lit the awful flame.
'Tis nothing to you that hill and plain
Yield sheaves of dead men amid the grain;
And widows mourn for their loved ones slain,
  And mothers curse your name.

But after the Day there's a price to pay
  For the sleepers under the sod.
And He you have mocked for many a day—
Listen, and hear what He has to say:
" Vengeance is Mine, I will repay!"
  What can you say to God?

# The Canadian Practitioner and Review

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## Original Communications

### POINTS ON GENERAL ANAESTHESIA FOR THE SURGEON *


By Dr. Samuel Johnston,

Anæsthetist, Toronto General Hospital.


The surgeon is very often obliged to operate under adverse conditions, having at times to work with unskilled assistants, and my remarks will be made in the hope of being of some help when a surgeon finds himself in such a position.

First, I think every surgeon should be able to say what anæsthetic should be given for certain cases, and the manner of administration, and to this end I will cite a few outstanding cases which require special care.

*Case A*—A patient suffering from intestinal obstruction, with fæcal vomiting:

We find the patient toxic, suffering from profound shock, the radial pulse being imperceptible. In this case nitrous-oxide is contra-indicated, on account of increasing the embarrassment of respiration, which has already been impeded by distension of the abdomen pressing on the diaphragm.

Ethyl-chloride is contra-indicated because of the depressing effect on circulation, where there is already toxæmia and poor circulation, and chloroform would add more fuel to the fire, so we have only ether to resort to, which I consider the safest anæsthetic. This should be administered very carefully, and slowly, on an open mask, and when the patient has reached the second stage of anæsthesia, the stomach tube should be

*Read before the Surgical Section of the Toronto Academy of Medicine, March 20th, 1917.

inserted in order to allow the contents of the stomach to pass out. The stomach should be washed, and the tube left *in situ*. If, during this procedure, a towel is placed over the mouth and nose, surrounding the tube, a little ether may be dropped on the towel to prevent the patient from returning to consciousness. At this juncture the operation may be proceeded with, and if there is any regurgitation into the stomach from the intestine, it will have exit through the stomach-tube. If any of the contents of the stomach are already in the larynx, with a pair of forceps, insert soft gauze into the throat, to absorb what is there, and this treatment should be persisted in until all fluid is eliminated. At the same time, only enough of the anæsthetic should be administered to keep the patient quiet, as this type of patient is already partially anæsthetised by the toxins and shock.

*Case B*—Patient suffering from loss of blood:

In this case chloroform is contra-indicated on account of its depressing effect on circulation, where vitality is already very low.

Ethyl-chloride is contra-indicated for the same reason, being next to chloroform in its toxicity.

We have left ether and nitrous-oxide and oxygen to choose from, and of these two ether acts as a stimulant, but is more toxic than the nitrous-oxide and oxygen. In such cases as this, there is little embarrassment in respiration (unless there is hæmorrhage into the abdominal cavity), when ether would be indicated. Otherwise nitrous-oxide and oxygen would be the safest anæsthetic, but asphyxia must be avoided.

*Case C*—Patient suffering from pulmonary disease, either chronic or acute:

In these cases, one must be in a position to change the anæsthetic and the mode of administration at any moment. Respiration is already embarrassed and nitrous-oxide, ethyl-chloride, or ether may increase this condition. Chloroform is the least irritating anæsthetic, but as circulation is usually very much interfered with, and the heart muscle affected, it must be administered with extreme caution. Probably better results would be obtained by adding a little ether to the chloroform, and after the patient is anæsthetised with chloroform, or a mixture of chloroform and ether, change to ether, as the irritation will be allayed and ether will overcome any depression caused by the chloroform. But if ether should produce irritation, nitrous-oxide and oxygen may be resorted to, or if this

is not available, return to the chloroform and ether mixture, in order to complete the operation. It requires judgment in all these cases to know just when to change from one anæsthetic to another..

*Case D*—Brain surgery:

In cases of brain surgery patients usually take any anæsthetic fairly well. But it is essential that a patient should be anæsthetised without having any congestion, and the choice of an anæsthetic will depend very much on the type of patient.

If the patient is plethoric, or has hardening of the vessels, it is better to begin the anæsthetic with either chloroform or chloroform and ether mixture, and when the patient is past the stage of irritation change to ether on the mask.

If, on the other hand, the patient is delicate and slight, anæsthesia may be induced with nitrous-oxide and oxygen and sustained with ether throughout.

Some surgeons prefer chloroform exclusively, in brain surgery, for the reason that the blood-pressure is lowered by it, and, consequently, they think less hæmorrhage is produced. This contention appears to me a fallacy, as the action of chloroform produces such profound depression on the circulatory system, and affects the unstriated muscle in the walls of the vessels, so that there is not the same recoil, when a vessel is cut, and hence hæmorrhage is more profuse. My opinion, gained from personal experience, is that it is not so much the drug that is used that increases the amount of hæmorrhage as it is the manner in which the drug is administered.

A striking example of the difference in the effects of the two drugs, ether and chloroform, is to be found in the practice of obstetrics. A patient is much less prone to post-partum hæmorrhage where ether is given than where chloroform is administered.

### Danger Signals.

The surgeon should be able to recognize signs of danger that may be developing, and be able to direct what should be done to obviate disaster.

For instance, with regard to breathing, if the respiration becomes faster and more shallow, or faster and deeper, under anæsthesia, there is some reason for this, and the anæsthetic should be discontinued, until it has been ascertained as to whether this is due to too deep or to too light anæsthesia. If respiration is stertorous, it is an indication that the patient is

not getting sufficient air. If inspiration becomes short and expiration prolonged, it is a very grave sign, as the patient is either too deeply under or is suffering from shock due to the operation, or both.

If the breathing becomes very quiet and shallow, although it may be regular, the patient is either too deeply or too lightly under. The anæsthetic must be discontinued until the two stages are differentiated.

Sometimes the respiration will resemble Cheyne-Stokes. This is always serious.

Noisy breathing, associated with cyanosis, shows that there is some obstruction of the air-way.

Laryngeal spasm may be caused by obstruction of some kind, or an irritable throat, or it may be due to too rapid administration of the drug, or it may be some impurity in the drug.

As to circulation, if the color changes from normal to purple, and from that to pallor, the pulse will soon change for the worse. If pallor alone is present, the circulation has become depressed, either from too much of the anæsthetic or from shock of the operation, or both. Pallor sometimes will occur, when a patient is too lightly under, owing to the vomiting reflex beginning to manifest itself.

If the ears or the lips become pale, it is always a sign that circulation is failing. With these changes in color, there is always a corresponding change in the pulse.

If the pulse becomes quick and small, or irregular, this indicates that circulation is being seriously affected. One cannot disassociate the color and the pulse. The former is the indicator of the latter.

With these changes in respiration and circulation, the pupil will also vary. Oftentimes the first indication that anything is wrong will be shown in the pupillary reflex. If the pupil dilates widely, and the color becomes pale or livid, and the pulse changes for the worse, the patient is in a serious condition.

Sometimes the pupil will dilate widely, although the color and the pulse may be good. This may be due to a reflex from the manipulations of the surgeon, the patient being too lightly anæsthetised.

In closing, I would like to say a word regarding the manipulation of the surgeon. Some surgeons appreciate more than others the importance of the bad effect produced on the patient by trauma. A patient may be more profoundly shocked, and

have a much more trying convalescence, from an operation lasting only half an hour, where the intestines or other organs of the body have been roughly handled, than the same patient would have, should the operation last an hour or more, and the surgeon exercise gentleness throughout.

I might add that I am glad that some of the surgeons know enough about the art of anæsthesia to appreciate the difficulties that the anæsthetist so often encounters, and I hope the time will soon come when all surgeons will have so intelligent a knowledge of this subject than when the surgeons themselves are embarrassed in their own work, in cases where the patient is not doing well under the anæsthetic, that they will not, in turn, embarrass the anæsthetist, but rather assist him, for it may be that this will mean the turning-point in the saving of the patient's life.

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## THE CANCER PROBLEM *

By C. H. Mayo, M.D., Rochester, Minnesota.

Through the study of comparative anatomy and embryology the anomalies of life have only recently become easier of explanation. It is shown that each life higher in the scale of evolution is subject to anomalies such as would be normal to some life lower in the scale. Is it not possible that the cancer problem may in time be worked out in all its details on the basis of primitive life?

Cancer is created in some manner by the division of one cell failing to carry with it the centrosome, the next division leaves it without control as a unicellular type of life capable of lawless growth more or less true to type but without a controlling brain. In reversion of type, the cell becomes parasitic in existence, creating nests of cells, fungating growth, ulceration and degeneration of connective tissue, according to the location, tissue and blood supply and reaction to irritation, and primarily changing the local field into a slightly acid one as an environment suitable for its growth. Ultimately this fluid permeates the body, a curious cancer cachæxia occurs and with

* Presented before the Ontario Medical Association, May 30th, 1918.

it there may be metastases later becoming manifest by growth at any point where cells may be carried. Before this it occurs in adjacent local lymph glands permeated by the fluid, and cancer grows freely in them. It is this need for proper chemical fluid environment that explains why cancer cannot be transmitted into higher types of life, but can be transmitted in the lower. This explains the metastases occurring in cachæxia, the whole body being in an acceptable fluid state.

Cancer continues to be one of the greatest of modern scourges. The disease apparently is on the increase, especially among the more highly civilized races. It may possibly be more prevalent than is suspected among lower types of the human race.

In cancer there is a local lawless cell growth. There must be, then, either a local cell fertilizing agent or a local loss of control over cell growth, and the study becomes one of the individual cell, the actions of which are best observed in early cell life. After maturity is reached, there are few structures capable of cell growth, yet the thyroid, a dynamic organ controlling energy output, is subject to hyperplasia, the liver, a most necessary organ, is subject to regenerative growth.

Discussion, investigation and discovery have been the means of controlling other great life-destroying diseases. Statistics show a marvellous improvement in the control and care of tuberculosis, and of pneumonia, while cancer, apoplexy, nephritis, and diseases of the heart have all been increasing. The greatest advance, however, in our knowledge of disease has come from a study of the individual cell. Educational propaganda has been of incalculable value in the prevention of cancer by early treatment, by the removal of benign tumors, and by the avoidance of irritation. It is probable that there are continually two hundred thousand people in this country suffering from the disease, and approximately eighty thousand die each year of the disease.

While cancer may be found at any age, it does not commonly occur in persons under thirty-five years and it rarely occurs in persons under twenty years. The resistent influence of youth may lie in the rapid reduction and restoration to normal of the acidity necessary to remove the ashes and waste developed in cell activity, and young cells have not exhausted the protoplasmic control bodies. In old age with hardening of the tissues, it is easier for a centrosome to be immature in its development and it may wholly fail.

In considering this chemical theory of cancer as influencing vicious cell growth, it is noted that one-third of the cancers affecting man, 38 per cent. in men and 22 per cent. in women, are found where acidity is constant and high, as compared with other tissues such as in the stomach. In ulcer, the gastric secretion is high in free acid. When cancer develops, combined acids increase and free acid diminishes or disappears, and the activity of pepsin is reduced or destroyed, regardless of the presence of combined acids. In accordance with this hypothesis peptic ulcer and cancer would occur but rarely in the non-acid achlorhydric stomach, since destructive growths and destructive bacteria are most harmful in the acid environment. The duodenum, which by right of continuity of tissue and close association, and opportunity for grafting from cancer in the stomach, is far more commonly affected by ulceration than is the stomach, but it is rarely affected by cancer, which, nevertheless, may spread from the stomach into all other tissues and structures surrounding it and at distant points in the abdomen. Ulcers occur in the stomach about one-third as frequently as in the first portion of the duodenum. A large percentage of gastric cancers give a history of preceding ulcer. Ulcer, then, is more common in the naturally alkaline duodenum, which is periodically bathed with the acids from the stomach. The neutralizing process occurs in the first portion of the duodenum. Ulcer or cancer is very rare in the duodenum below the first two or three inches, although cancer occasionally occurs in this organ by penetrating through a duct. Cancer occurs but two times in the whole length of the alkaline small intestine to ninety-eight times in the large bowel. The colon is frequently affected by cancer because here again there is acidity, and 75 per cent. of cancers are located in the fixed and tissue-surrounded portion of the colon, which retains the dry and harder contents as a traumatic agent. The same statement may be made concerning the development of cancer in other fields, either normal or degenerative, that is, the urinary bladder, the cervix and the mouth. The mammary gland, the uterus and the prostate are subject to carcinoma, being tissues in which degeneration is a normal process and having but a limited period of functional activity.

Ulceration, under proper conditions, may permit cancer to develop. The ulcerative process itself is usually of bacterial origin, and the bacteria are carried by the circulation, local conditions of infection being developed through capillary in-

fractions. It is very probable that the essential factor in the development of carcinoma is a derangement inside of the single cell, in an acid field and that the single cell carried through the lymphatics or into the circulation is the cause of metastasis. In the peritoneum and on the surface, grafting is common and it is occasionally seen in epithelial and mucous surfaces.

It is evident that cancer is on the increase among the more highly civilized people; the enormous percentage occurring in the stomach would indicate that this organ receives the greatest abuse.

We have then in cancer a cell with lost control, destroying its community existence and reverting back to primitive life. It has a natural acid environment or an acquired one incident to local degeneration which may be normal, as in the stomach, or incident to normal degeneration as in the breast and uterus, or the degeneration of age.

The part played by chronic traumatism or irritation in the development of cancer is positive and definite to a degree. The danger of cancer is increased by all irritation or traumatism which demands a continued cell repair and it is in proportion to that demand. Ultimately exhaustion of cell control bodies occurs, modified by age limitations and chemical surroundings. Such areas offer an increasing opportunity for the half of a dividing cell to revert to the unicellular type of life and to become parasitic and cancerous.

If the cells are involved they must be of the immature or waiting type, and further progress in the study of cancer can come only through a study of the individual cell of the multicellular and unicellular organisms, in order to select more definitely the one or more bodies which may be involved in the control of its protoplasm.

### Treatment.

Removal by any method is effective, if early, whether by knife, paste, cautery, rays or radium. Removal of the local growth is not effective if the glands are involved, more extensive dissection being required in addition to gland removal.

The effect of rays may be to lower the permanency of the control bodies of the cell; thus prolonged X-ray treatment without protective shields, for certain types of rays, adds a factor of danger in the production of cancer.

# Editorials

## EPIDEMIC INFLUENZA

The Ontario Board of Health has issued an abstract on influenza taken from the *J.A.M.C.* In it we are told that the treatment of the disease is largely symptomatic. To relieve the pain acetyl-salicylic acid and acetphenetidin are recommended. We are sorry to see such remedies advised, with directions to continue "until symptomatic relief is secured." The salicylates combined with coal tar products form combinations which are very depressing, and if given at all should only be continued for a short period, say four doses. If these four doses relieve the pains, then a dose of veronal, five to seven grains, has usually a good effect. Dover's powder is an admirable remedy in such cases, but should be administered with care, because it frequently upsets the stomach. It is perhaps safer to commence with an opiate, nothing being better than some preparation of codein. Plain opium or morphine answers very well. Of course we presume that in the meantime the patient is kept in bed, that being really the most important point in treatment. After we have relieved pain, supporting treatment is essential. In certain cases stimulation is, we believe, necessary, especially if there is lung involvement (commonly called broncho-pneumonia). A great many of our best therapeutists have found that for supporting and building up, alcohol in some form and camphor hypodermically are the two best agents. Then, to bring back muscular tone and strength, strychnine.

It was hoped by many that vaccination would prove a preventative, but the foundations for any hopes of that sort cannot yet be said to be secure. As a matter of fact, although careful bacteriologists and clinicians have been studying the subject for ten years or more, those best qualified to express an opinion say that vaccination and inoculation as preventive measures are still in the experimental stage.

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## KING GEORGE AND QUEEN MARY

We learn from a very interesting article published in the *Hospital*, London, England, that King George and Queen Mary celebrated the twenty-fifth anniversary of their wedding, July 6th. We are told in the article that King George became a cadet in the Royal Navy forty-one years ago, and since that time his life has been one of continuous activity, including an amount of hard work and hard study and reading, which few probably realize. His work has been done in such a quiet and unassuming way that it has not perhaps been appreciated as much as it deserves. There are few places on the war fronts which His Majesty has not visited in person, stimulating his sailors and soldiers by his presence, applauding their valor, and condoling with their sufferings and bereavements. Her Majesty the Queen has been indefatigable in good works in hospitals and elsewhere.

The article concludes as follows: "The King's personal work has been thoroughly well done, and his knowledge to-day of the conditions under which his

subjects live and work is more complete and thorough probably than that possessed by any previous king. England and the Empire have many blessings to be thankful for, and in the circumstances of the present time they have had few greater than the presence on the throne of King George and Queen Mary."

## THE LLANDOVERY CASTLE OUTRAGE

King George heard, July 11th, the story of the sinking of the hospital ship *Llandovery Castle* from one of the survivors, Sergeant Arthur Knight, of the Canadian Army Medical Corps, who was summoned to Buckingham Palace. Sergeant Knight was closely questioned by the King, especially as to what happened after the vessel was torpedoed, and His Majesty expressed his intense horror of the German outrage.

The conversation was private, but Sergeant Knight repeated his story to a representative of the *Times* afterwards. He told how, after the torpedo had struck the ship, he was able to get into a small boat with nine men and fourteen nursing sisters. The boat was capsized and sucked in by the sinking ship, but he got hold of a piece of timber and floated about for some time, when a boat came alongside, and he was pulled on board. It was then dark, and he heard an order in fairly good English to come alongside of a submarine. Someone replied, "We are trying to save others." The answer was, "If you do not come alongside at once you will find my big gun at you." On coming with a jar against the side of the submarine the sergeant grabbed hold of some projec-

tion and scrambled on board. Seven or eight young Germans gathered around him and asked in English, "What do you want?" But without waiting for a reply four of them seized him and pitched him back into the boat, in which were twenty-four people, who were ordered "to get away quick." "We obeyed, but the submarine came after us, and seemed to be trying to down us with her wash. We saw a submarine rushing about among the wreckage, apparently trying to ram any other boat that might be afloat. Our boat got away, but for the next fifteen minutes we heard heavy reports and shells passed screaming over us." He counted twenty shots, and concluded that the survivors in the water were being fired upon. They pulled all night and all the next day, and were finally picked up by the *Lysander*.

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## RED CROSS DONATION TO CANADA

The War Council of the American Red Cross has contributed without restrictions $500,000 for the relief of Canadian soldiers at the front, and with the gift sent a copy of the following preamble:

"Whereas, the American people profoundly and gratefully recognize the devotion of the Canadian people and the armed forces of Canada in the great war and are deeply appreciative of the spirit of heroism and self-sacrifice with which so many Americans have fought and died as members of the Canadian forces during the past years, and it is highly appropriate that the American Red Cross should extend to the Canadian soldiers a measure of assistance toward their relief and comfort; and,

"Whereas, such tribute cannot be translated more serviceably or appropriately than by a gift through the Canadian Red Cross, and it is the desire of the American Red Cross to afford substantial recognition of the sentiment of brotherhood and sympathy which pervades this country in this present crisis of human affairs."

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## PRE-OPERATIVE PURGATION

We are told by the *J. A. M. A.* that Alverez, of the Hooper Foundation for Medical Research, states positively that purgation as a routine pre-operative procedure should be abolished. After vigorous catharsis, the isolated musculature is fatigued with greater readiness, the bowel may become distended with gas and fluid, and the peristalsis is deviated from its usual manifestations. The result is, at least in some cases, gas, distention, ileus, nausea and vomiting after surgical operations. An American surgeon has asked what is expected to be gained through preparatory evacuation. The *Journal* appears to think nothing. It doubts whether anything seriously toxic is removed by such catharsis, and as the procedure is attended by fatigue and loss of sleep, it is likely to be a detriment and the cause of post-operative discomfort. Catharsis also leads to loss of water and intestinal secretion, which causes more or less distress. Doctor Peet, who has also written on the subject, recommends a simple enema without any laxative being administered by mouth.

# News Items

### A Cruel Injustice

Much sympathy was felt for Miss Isobel Brown, of Bracebridge, because of the sad mistake which resulted in her arrest on a charge of administering poison because somebody became ill after eating jelly prepared by her. She came under suspicion, was arrested, and has been some days in jail, pending investigation. A careful examination showed that there was absolutely no foundation for the cruel charge which was made against her. No one seems to know exactly who was responsible for this terrible mistake. The victim was only a cook, apparently without friends, and was compelled to serve her time in prison while the matter was being investigated.

It will be noticed that this did not happen in Belgium nor any country overrun by the Germans or Turks. It happened in the great Province of Ontario, in the free and enlightened Dominion of Canada.

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### Peel County Medical Association

The Peel County Medical Association held their sixth annual meeting in the Great War Veterans' Association's apartments at Brampton, October the 10th, and it was one of the most successful and highly instructive meetings ever held in the County of Peel.

Dr. John W. S. McCullough, Secretary of the Provincial Board of Health, was the first to appear before the meeting, in his usual pleasing style, and read a most interesting and instructive paper on "Communicable Diseases," which was quite appropriate just now, with the advent of the "Spanish Flu" in this part of the province. The Peel County doctors also had an intellectual treat in a paper read by Dr. K. C. McIlwraith, of Toronto, on "Obstetrics—the Ante and Postpartum Care of the Patient." It was listened to with the profoundest interest, touching as it did the vital necessities of the country doctor.

Then last, but not least, Dr. S. M. Hay, of Toronto, read a paper on "Surgery—the Diagnosis and Treatment of Some Acute Abdominal Conditions." The Association feels under

the deepest obligation to the doctor for his most valued and highly appreciated paper. Dr. Alan Brown, of Toronto, intended to be present and read a paper on diseases of children, "Malnutrition of Infant," but, owing to illness, was obliged to cancel the engagement.

On behalf of the Association, the Secretary expresses their deep appreciation for the services of the men who so ably assisted in making the meeting such a decided success.

The Society has arranged with the O.M.A. to hold a series of meetings in the county during the autumn and winter, which will be highly appreciated by doctors who are unable to take post-graduate courses.

The officers were all re-elected for the ensuing year, namely: Dr. Bowie, Streetsville, President; Dr. Heggie, Brampton, Vice-President; Dr. Reynar, Palgrave, Secretary-Treasurer; Drs. Thomas, Bryden and Bateman, Executive Committee.

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### Air Training Casualties

It was supposed by many that accidents in the Air Service have been excessively frequent in Canada. A statement came from headquarters, September 12th, that in the Canadian Training Service, out of 36,000 flights, there were 59 "crashes." Statistics of accidents in English camps showed that out of 9,000 flights there were 58 crashes. Thus it will be seen that proportionately the accidents in England were more numerous than in Canada, and we understand that they have been more numerous in the United States than they have been in either England or Canada.

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### Doctors and the Influenza

We know of no epidemic which has occurred in Canada in which physicians have suffered so seriously as that of the so-called Spanish influenza. The proportion of those attacked has been large with a high death rate. Among those who have died are Dr. Jessop, M.P.P., St. Catharines; Dr. J. P. Rutherford, Chatham; Dr. W. C. Swenerton, Vancouver; Dr. Norman Beal, London; Dr. Robt. McClure, Port Elgin; Dr. J. A. Johnston, Stayner; Dr. A. W. Stinson, Cobourg; Dr. R. W. Munro, Smithville; Dr. R. W. Faulds, Elmira; Dr. Kenneth MacKinnon, Guelph; Dr. W. A. Sargent, Colborne, and many others.

We have to report with regret that Dr. Canfield, for some years M.O.H. of Ingersoll, was dismissed from office October 8th by a unanimous vote of the council of that town, acting on a recommendation from the Local Board of Health. The cause of dismissal was alleged lack of discretion by the Health Officer. Major Buchanan, of Ingersoll, was authorized to choose a new officer at a salary of $200, instead of $50, which had been given to Dr. Canfield.

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Dr. McCullough, C.O.H., Ontario, issued a statement, October 17th, with the reports of deaths from influenza from various districts in the Province, indicating that few old people have been affected by the malady. Of the 106 deaths reported up to that time the ages were as follows: from 1 to 15 years, 11; 20 to 30 years, 65; 35 to 45 years, 23; 55 to 65 years, 5; and 75 to 80 years, 2.

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It was reported September 14th that Lt.-Col. Stanley Ryerson had resigned his position as Assistant Director of Medical Services of the Toronto Military District, in order that he might retire to civil life and resume practice. Dr. Ryerson went overseas with the Toronto University Hospital Unit, and after serving some time at Saloniki returned to Toronto in January, 1917. In March, 1917, he was appointed Assistant Director in the place of Colonel Marlow, resigned.

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We learn from English sources that an Australian, who was a journalist before he became a soldier in this war, was wounded in the third battle of Ypres. In the course of time he was brought to the Ontario Military Hospital at Orpington. In a detailed description published by him in an English medical journal, he plainly indicates that in his opinion this hospital is as nearly complete in all respects as anything can be in this world. In referring to the working staff, he speaks as follows: The frank courtesy of all grades of the staff is a reflex of the generous outlook of a sister nation, and an indication that the links that bind us are not of expediency's forging, but were made in the fire of mutual idealism.

It is reported that the United States Government has resolved before next March to pass such legislation as will make child labor impossible in the future.

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Mrs. Russell, wife of the late Dr. Thomas Russell, formerly Superintendent Hospital for Insane, Hamilton, died October 20th, after a very few days' illness.

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Capt. S. Murphy, killed in action October 14th, was the son of the late Dr. J. B. Murphy, for many years Superintendent of the Hospital for Insane, Brockville.

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The Honorable Dr. H. S. Beland, who was a prisoner in Germany for four years, lectured at North Bay, October 18th, and on his return journey to his home spent the greater part of the 19th in Toronto.

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Mrs. Thomas, wife of Dr. Clarence P. Thomas, of New York City, and only daughter of Dr. P. E. Doolittle, Toronto, died at her home, October 18th, after a brief illness from pneumonia.

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At a meeting of the Elgin County and St. Thomas Medical Association, October 9th, a new Advisory Board recommended that a new hospital be built on a new site in St. Thomas, as the Amasa Wood Hospital is inadequate for the city's present need.

# C.A.M.C. News

The following have been placed on Reserve of Officers from the personnel of the C.A.M.C. for civilian duty, as stated:—

BOARD OF PENSION COMMISSIONERS.

Lt.-Col. J. L. Biggar, Victoria, B.C.
Major D. McLaughlin, Calgary, Alberta.
Captain B. F. Keillor, Dundee, Ontario.
Captain A. E. Hilker, Hamilton, Ontario.
Captain E. H. Orok, Winnipeg, Manitoba.

INVALIDED SOLDIERS' COMMISSION.

Major E. E. Latta, Colborne, Ontario.
Captain G. W. Howland, Toronto, Ontario.
Captain G. G. Stewart, Camrose, Alberta.

C.A.M.C. APPOINTMENTS.

Lt.-Col. D. McGillivray (Toronto) has requested to be relieved of his duties on the Board of Consultants. He is to be replaced by Lt.-Col. Parsons, Toronto.

Colonel K. Cameron becomes O.C. St. Anne de Bellevue Military Hospital.

Lt.-Col. C. E. Doherty becomes A.D.M.S. at Victoria, B.C.

Lt.-Col. J. A. Grant, P.A.M.C., is appointed to the Board of Revision, Ottawa.

Lt.-Col. J. M. Gunn becomes D.A.D.M.S., Calgary, Alberta.

Captain C. M. Pratt becomes D.A.D.M.S. at St. John, N.B.

Captain E. H. Young becomes O.C., Ontario Military Hospital, Cobourg, Ont.

Captain G. W. Armstrong assumes command of the A.M.C. Depot at Toronto.

Captain G. D. Gordon assumes command of the Petawawa Camp Hospital.

Major C. E. Fortin becomes Officer in Command of Venereal Disease, Winnipeg.

Colonel F. S. L. Ford for duty at Militia Headquarters, Ottawa.

Major R. L. Miller becomes D.A.D.M.S. at Victoria, B.C.

### Returned from Overseas.

Lt.-Cols. Biggar and Parsons; Majors J. J. Ower, A. J. Losier and H. B. Jeffs; Captains A. A. Drinnan, E. C. Beer, G. A. Campbell, W. V. Jackson, T. B. Green, W. A. Hutton, L. W. Houghton and F. W. Jackson.

### Promotions.

To be Colonel: Lt.-Col. J. A. Gunn, Winnipeg.

To be Colonel: Majors W. A. Gardner, P. K. Menzies, E. V. Hogan, W. M. Hart, T. H. MacDonald, W. H. K. Anderson, N. B. Gwynn, H. H. Moshier.

To be Major: Captains F. W. Tidmarsh, R. Pearse, J. J. Thompson, R. L. Miller, T. Morrison and A. J. Swan.

### Retirements.

The following have retired as medically unfit: Captains E. Bice, I. Wilson, R. J. Wilson, C. A. Ames, W. H. Brothers, R. L. Parr, and Lieut. E. H. Booth.

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**Making Him Wince**

Oberlieut. Kraut—(Translated.) We have the honor to present six Americans captured this morning by a company of fifty men. Enter two negroes, a Chinaman and three whites (an Italian, a Pole and a Connecticut Yankee), all much worn, yet slightly amused.

Kaiser Wilhelm—Where are the brave fifty? Bring them in that I may decorate each with an iron cross.

Oberlieut. Kraut—I regret to report that but nine remain alive.

Private Rastus Johnson—An' if ah had only had mah razah you all could have saved dem nine iron crosses.

# Personals

Dr. Leslie C. Coleman, from India, visited Toronto early in November.

Dr. J. D. McDonald was appointed M.O.H., Ingersoll, at a salary of $200.00, October 18th.

At a recent meeting of the Orillia Curling Club, Dr. A. R. Harvie was elected Patron, and Dr. A. H. McLean, President.

Major Thomas Archibald, C.A.M.C., has been removed from Whitby, and was appointed O.C. St. Andrew's Military Hospital, October 10th.

Dr. (Col.) Walter McKeown, of Toronto, is still overseas, and has been for some time O.C. Kitchener Army Hospital, Brighton, England.

Dr. Alan Brown, of Toronto, who was rather seriously ill for some time, left his home, October 30th, to recuperate at Atlantic City.

Capt. Roy Snider, R.A.M.C., son of the late Dr. R. O Snider, of Bathurst Street, Toronto, went overseas in 1916. After spending one year at Saloniki he went to England, where he remained for a short time. He was then sent to France where he received a somewhat serious gunshot wound in August.

Lt. Stanley Reaume, son of the Hon. Dr. Reaume, of Windsor, Ont., who went overseas with the 241st Battalion from Windsor, was reported "missing in action" October 8th. It is believed in Ottawa he was only wounded. He was twenty-four years of age and enlisted as a private at the outbreak of the war.

Dr. J. Ephraim Elliott, of Toronto, went to New York to meet his son, Lt. Leighton O. Elliott, who arrived in that city October 9th. Lieut. Elliott had been overseas serving in the artillery for over three years, and although he saw a great deal of active service, was very fortunate in receiving no wound at any time sufficient to knock him off work.

# Obituary

## HIRAM RICHMOND BARKER, M.D.

Dr. H. R. Barker died at his late residence, Sharbot Lake, Ont., October 20th. He was a son of the Rev. W. R. Barker, 173 Grenadier Road, and graduated in 1912.

## MAJOR J. HARVEY TODD, M.B.

The many friends of Dr. Harvey Todd, of 165 College St., Toronto, were both surprised and shocked when they heard that his death had occurred in Quebec, October 17th, after a week's illness, from pneumonia, following an attack of influenza. He was a son of Dr. J. A. Todd, of Toronto, and went overseas two years ago with the Mississauga Horse. A younger brother, an officer in the R.A.F., has been missing for several months, and is now presumed to be dead. Major Todd graduated M.B. from the University of Toronto in 1905. After doing some post-graduate work, he commenced practice in Toronto, and in addition to acquiring success as a general practitioner, he was recognized as one of our best experts in X-ray work.

## WALTER F. CHAPPEL, M.D., F.R.C.S., Eng.

Dr. W. F. Chappel, M.D., F.R.C.S. Eng., died at his late residence, East 55th Street, New York, aged 60. He was a son of Mrs. Mary Chappel, Sherbourne Street, Toronto, and received his medical education in Trinity Medical College, graduating in 1879. After graduating, he spent some time in post-graduate work, especially surgery, in London, England, and became F.R.C.S. Eng. Shortly after his return to this continent he commenced practice in New York City, where he soon achieved success.

## ALFRED W. NIXON, M.D., M.P.P.

Dr. A. W. Nixon, one of the best known physicians of Ontario, died at his home in Georgetown, October 4th. He graduated M.D. from Trinity University in 1890, and after passing the examination of the Ontario Medical Council, commenced practice in Georgetown. He soon acquired a large practice and great personal popularity. He was selected many years ago by the Conservatives of the County of Halton as their standard-bearer for the election for the Ontario Parliament. He was easily elected by a large majority, and was for many years one of the most popular members of the Ontario Parliament.

## C. H. FRANCEY, M.D.

Dr. C. H. Francey, a surgeon with the American Forces, died at Camp Eustis, Va., September 29th. He was born and educated in the Province of Ontario, and graduated from Trinity University in 1888. He also passed the examination of the Ontario Medical Council with the intention of practising in this Province. Shortly afterwards, however, he went to the United States, and when the war broke out joined the army as a surgeon of one of the battalions. The body was brought to his former home in Gormley, and buried on October 4th.

## JAMES EWART BROWN, M.D., L.R.C.P., Edin.

Dr. J. E. Brown, of 10 Carlton Street, died of influenza, Oct. 12th, aged 62. He graduated M.D. from Trinity University in 1884, and afterwards took a post-graduate course in Edinburgh and London. On his return to Canada he practised for a time in Stratford and later in Arkona. From there he went to the Klondike, where he spent two years. He lived in Toronto from 1904 until the time of his last illness. His son, Dr. W. E. Brown, of Carlton Street, Toronto, who was for some time on active service overseas, returned to Toronto some months ago. He unfortunately was so seriously ill that he was unable to see his father before he died.

## OSLER MONK GROVES, M.D., L.R.C.P. & S.

Dr. O. M. Groves died at his home in Carp, Ontario, Oct. 9th, of pneumonia, aged 33. He graduated M.D. from McGill in 1906, and after taking a post-graduate course in February, he commenced practice at Carp. His father, the late Dr. George Groves, who was also a graduate of McGill, practised many years in Carp.

## SYLVESTER LLOYD FREEL, M.D.

Dr. S. L. Freel died at his late residence, Stouffville, Sept. 30th, aged 78. Dr. Freel received his license to practice from the old Medical Board in 1866, and received the degree of M.D. from Victoria University in 1872. Dr. Freel was essentially a general practitioner of the best sort. He was conscientious and skillful, and kept always well abreast of the times. He was highly respected and much beloved by the inhabitants of Stouffville and the surrounding country.

## NEITHER DEAD NOR SLEEPING

The *C.M.A.J.* for November has a notice in its obituary columns stating that Dr. Thos. Cullen, a silver medallist of Toronto University in 1890, and Associate Professor of Gynæcology, Johns Hopkins University, died on September 14 at Baltimore. From a letter received from Dr. Cullen, dated Nov. 4, we got the impression that he was "very much alive" and quite well.

## MARRIAGE

Dorothy, only daughter of Dr. A. B. Welford, Woodstock, was married to Mr. Cuthbert Mughan, at Wildingham, Surrey, England, on September 10th.

# Book Reviews

*Clinical Diagnosis.* A Manual of Laboratory Methods. By James Campbell Todd, M.D., Professor of Pathology, University of Colorado. Fourth edition, revised and reset. 12mo of 687 pages, with 232 text-illustrations and 12 colored plates. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, 14s. net. Sole Canadian agents, The J. F. Hartz Co., Limited.

This is an excellent manual of clinical laboratory methods, as it deals with the subject largely from the standpoint of the practitioner, who desires simplicity in technique. The preliminary chapter, on the microscope, is to our mind one of the most useful chapters in the book, and will well repay reading by any microscopist.

The book is well illustrated with cuts and plates that are instructive. In the appendix will be found suggestions for the equipping of a small private laboratory, which is sure to prove of service to many.

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*A Manual of Otology.* By Gorham Bacon, A.B., M.D., F.A.C.S., formerly Professor of Otology in the College of Physicians and Surgeons, Columbia University, New York, etc., assisted by Truman Laurance Saunders, A.B., M.D., Assistant Professor of Laryngology and Otology, College of Physicians and Surgeons, Columbia University, New York, etc. Seventh edition, revised and enlarged, with 204 illustrations and 2 plates. Lea & Febiger, New York and Philadelphia, 1918.

It is hardly necessary to make an extensive criticism of a book which has reached its seventh edition and has thereby proved its value as a text-book for the student and a convenient manual for the general practitioner.

A certain amount of revision has been done, in particular recent work in labyrinthum disease has been included, together with the equilibrium tests required for the aviation service. This will make the present edition of particular interest to army surgeons. We are sure that continued popularity will be extended towards "Bacon's Otology."

*A Laboratory Manual of Qualitative Chemical Analysis.* By A. R. Bliss, Jr., M.D., Ph.G., Professor of Pharmacology, School of Medicine, Emory University, Atlanta, Ga.; formerly Professor of Chemistry and Pharmacology, Graduate School of Medicine, University of Alabama. Second edition, revised and reset. 194 pages, with working tables. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, $2.25 net. Sole Canadian agents, The J. F. Hartz Co., Limited.

As the introduction to chemistry and chemical analysis, this is an excellent laboratory manual for the beginner in the natural sciences. The great success of the first edition would indicate the need for such a book and we have no doubt that this, the second edition, will meet with the same hearty reception.

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*Gynæcology.* By William P. Graves, M.D., Professor of Gynæcology at Harvard Medical School. Second edition, thoroughly revised. Octavo volume of 883 pages, with 490 original illustrations, 100 of them in colors. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, $7.75 net. Sole Canadian agents, The J. F. Hartz Company, Limited.

It is with great pleasure that we note a second edition of "Gynæcology," by Dr. Graves. There are many works on gynæcology, published and illustrated, but this volume is exceedingly lucid. It deals concisely, and I might say, exhaustively, with the cases of female disorders. Those of neurotic nature as well as those due to mechanical injuries. The operative portion of the work is also exceedingly clear, and the descriptions of many operations so beautifully illustrated that there is no difficulty whatever in following the technique. The illustrations are by no means exaggerated, and the descriptions in the texts are easily followed. For instance, the part on cystocele and its cure, the illustrations and the texts have simplified the matter to such an extent that it quite places this troublesome matter in a very simple and clear light. One could multiply typical instance to no end.

We can thoroughly recommend the volume for the desk of physicians as a reference book at a time when he is in doubt as

to what procedure to follow, and can assure him that he will be safe in following the advice which is given in the text.

The typography and paper in this volume is far better than we would anticipate in war time, and the Saunders Company may be congratulated on the type—a size for easy reading as well as the excellent press work.

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*Military Orthopædic Surgery.* Prepared by the Orthopædic Council. Illustrated. Lea & Febiger, Philadelphia and New York, 1918.

This small pocket-size volume forms Medical War Manual No. 4, authorized by the United States Secretary of War, and under the supervision of the Surgeon-General and the Council of National Defense, and presents in an easily read, condensed style, a most complete manual on the physiology and pathology of orthopædic problems met with in the army.

As is frankly acknowledged extensive quotations, even whole chapters, have been taken from the writings of Col. Sir Robert Jones and others who have had the wide experience presented by active service conditions in the war. It is a book which should be in the library of every regimental medical officer, particularly one attached to an infantry regiment, while the surgeons at clearing or base hospitals will find abundant food for thought in its presentation of the treatment of bone and joint disabilities.

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**Passed Unanimously**

The physiology teacher was giving a day to a review of the work. The class was just considering the position of different organs of the body.

"And now, Johnny," she asked, "where are your bowels located?"

"I dunno!" said Johnny.

"But you knew yesterday," said teacher.

"Yes, ma'am," said Johnny, "but my bowels moved since yesterday."—*J. A. M. A.*

# Selected Article

## THE DISAPPOINTMENTS OF VACCINE TREATMENT

By H. G. Adamson, M.D., F.R.C.P.

The value of prophylactic vaccination has long been established, but considerable difference of opinion exists as to vaccination as a curative agent, and many who have given this treatment a prolonged trial are disappointed. Dermatology was one of the earliest fields for the trial of curative vaccines. There are two microbic affections, difficult to cure, in which vaccine therapy seemed likely to be useful—chronic staphylococcic infections and lupus vulgaris. But this early promise has not been fulfilled. A dermatologist will now hesitate before embarking a patient afflicted with sycosis or other chronic staphylococcal infection of the skin upon a course of vaccine treatment. He may, as a last resort, employ vaccines, but he will hesitate, since it is not possible to predict that the patient will eventually be benefited, and his expectations will generally be in inverse proportion to his experience of the treatment. In obstinate chronic staphylococcal infection good results are rare. Good results are occasionally observed in the less chronic forms of staphylococcal infection, in recent furunculosis, and in pustular acne which is not of long standing. But such results are by no means constant, and in the majority of cases there will be but temporary improvement, if really any improvement that cannot be attributed to other treatment carried out at the same time or to accidental coincidence with the natural course of events. In some cases the eruption will become worse. Few dermatologists now recommend tuberculin treatment in lupus vulgaris, and many avoid it as being fraught with danger. The writer's experience is that every case treated by tuberculin became less controllable.

In other fields the same views prevail. The discussions on vaccine therapy at the Royal Society of Medicine in 1910 and in 1914 show that although the treatment may now and then appear to give dramatically successful results, it more often fails, and sometimes does harm. Sir Thomas Horder sum-

med up the opinion of many. "The failures of vaccine treatment are more frequent than its successes." In respect to vaccine treatment in enteric fever, gonorrhœa, and ulcerative endocarditis, there are differences of opinion, and many are dissatisfied with the results. In septic wounds of war curative vaccine therapy has proved of little value. Wright says, "Treatment by physiological methods . . . procedure such as the opening and draining of the wound is beyond all comparison the most important, and I would admit that antiseptic treatment is at the best an ancillary method, and the same applies also to treatment by vaccines." This is a distinct recession from his opinion in 1909: "The principle of building up the resisting power of the system against any microbe which may have entered the body will ultimately hold its own even against the principle of warding off infection from the susceptible patient."

How are we to account for this comparative failure of curative vaccination as contrasted with the striking success of prophylactic vaccination? Prophylactic vaccination is a less intricate problem and a procedure better supported by facts than curative vaccination. Preventive vaccination has a sound foundation. It has been shown that when an animal becomes infected, it is rendered, after a period of incubation, supersensitised to the toxins of the microbe. A condition of allergy or altered reactivity is produced, and protects the animal against a second infection. An attempt to produce a second infection gives rise to a reaction more violent than the reaction to the first infection, which has a shorter incubation period and which ends in spontaneous cure. The efficacy of prophylactic vaccination against small-pox and against enteric fever is demonstrated. But the cure of an existing infection is a different problem. The protection acquired against a second infection varies in degree and in duration in different diseases. In certain infections such as small-pox and scarlet fever, the organism completely overcomes the invasion and remains for many years, or, partially, even for a lifetime, protected against the disease.

In a second class the patient, although protected against a second invasion from without, yet remains infected and is liable to new infections from within (auto-inoculations). This occurs in tuberculosis and in syphilis. In a third class the protection is apparently of but short duration and seems

often to be followed by a period of increased susceptibility, so that new infections may easily take place. This is seen in streptococcal and staphylococcal infections and in influenza. What we require to know in regard to the second and third class is whether in a subject whose immunity development has been insufficient to overcome completely the infection we can by appropriate doses of vaccines so enhance the production of immune bodies—*i.e.*, so "build up" the resisting power against a microbe—that the defeat of its invasion is assisted or completed; and whether we can do this without danger of disorganizing the mechanism of immunity and possibly lowering instead of raising the powers of resistance.

The early promise of Wright's method of curative vaccination was that he could avoid the danger of over-stimulation and its risks of fresh infection, such as occurred in the early days of treatment by Koch's old tuberculin, by regulation of the dosage, and that we could enhance the production of protective bodies without so disturbing the mechanism of immunity as to do harm. This method was based upon the hypothesis "that the blood of those who become the subject of a bacterial invasion is deficient in protective substances," and "that by an injection of corresponding bacterial vaccines the content of the blood in protective substances can in practically all cases be increased." These protective substances were "hypothetical substances in the serum which incite phagocytosis by action on bacteria—*i.e.*, opsonins. It was further maintained that the measure of the production of protective substances could be gauged by the opsonic index and the appropriate doses of vaccine measured accordingly.

If this simple hypothesis expressed the whole problem of immunity vaccine treatment would be a straightforward procedure. But it ignores the fact that an infected organism develops specific immune bodies as a consequence of becoming infected. A patient with lupus vulgaris is protected against fresh infection because he has acquired protective bodies which are absent in the normal person. Although the average "opsonic index" of lupus cases has been found to be 25 per cent. below normal, yet every case of lupus gives a "cutireaction" to tuberculin, and thus indicates a body content of protective substances above the normal.

Again, in enteric fever agglutinins are present in the blood which are absent or deficient in the normal. Yet the hypo-

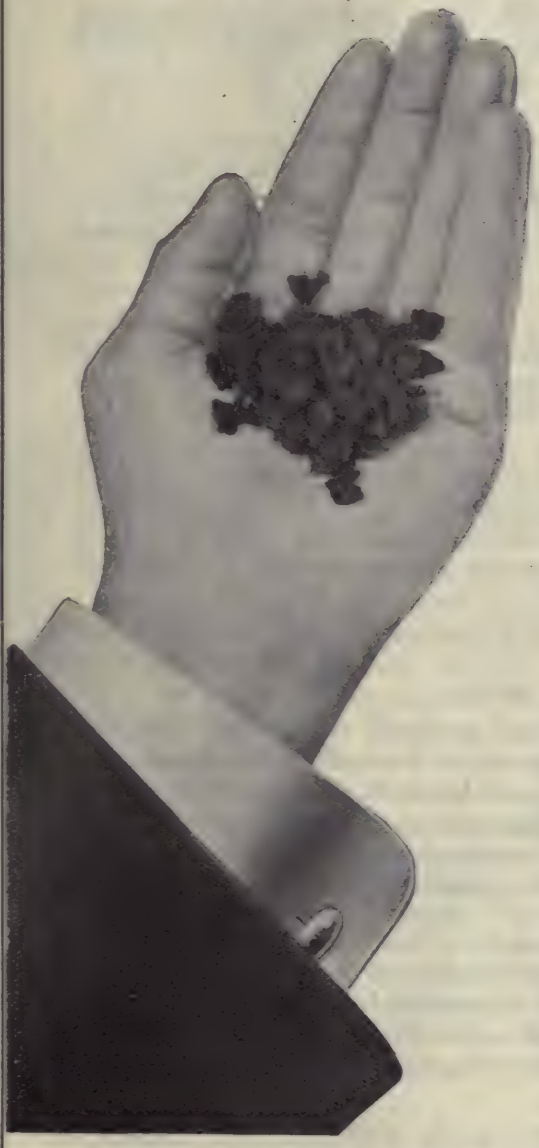
thesis of Wright supposed the blood of the enteric patient to be deficient in protective substances. Moreover he supposes that these bodies can be developed as a result of vaccination, although they cannot as a result of infection, an attitude which seems contradictory.

It is doubtless true that immunity reactions may be stimulated by vaccination, but an infected person is in a state of allergy (hypersensitiveness) towards the toxins of microbes by which he is infected, so that the reaction from even a minute dose of vaccine may be enormous in proportion to that which would occur in the uninfected, and such excessive reaction may be followed by a period of exhaustion of immunity or "anergy." This seems to be the danger of so-called curative vaccination, as we cannot estimate the result of a vaccine in an already infected subject. The minutest dose may set up an explosive reaction which cannot be predicted or controlled.

According to Wright's hypothesis the proper dose of a vaccine may be estimated by the opsonic index. But this hypothesis ignores the fact that in many infections the polynuclear leucocytes or phagocytes take little, if any, part in the defence against the microbe. In tuberculosis, for example, the cellular defence is a connective-tissue-cell defence and one in which the polynuclear leucocytes appear to take no part. Moreover, the opsonic index as a measure of the production of protective bodies by vaccination has proved altogether unreliable. For in 1904 1/500-1/20 mg. of new tuberculin was regarded as an "extraordinarily small dose." In 1906 Wright said: "I now begin with a quantum of tuberculin corresponding to not more than 1/1000 milligram of T.B. powder and never advance to doses larger than 1/600 mg." In 1910 the doses were from the beginning 1/20,000 mg. to 1/4000 mg. These doses were from the beginning controlled by observation of the opsonic index, and the earlier cases were reported as doing well with doses a great deal larger than those afterwards advised.

Turning to staphylococcal infections in the defence against which the polynuclears do take an important part, and in which the opsonic index might more reasonably have been supposed to be of assistance, the same discrepancy exists. In 1903 the opsonic index told us the proper dose was from 2500-5000 million staphylococci and that the index could be controlled and cases cured by these doses; but in 1908 the dose was reduced to 100-250 millions. Have we any reliable means of knowing the proper dose of vaccine?

# GRAPE-NUTS



**Held in the hand—**

reveals shining crystalline particles upon its granules—significant of the breaking down of starch into that rich, grain sugar which abounds so freely in this food.

The sugar in Grape-Nuts is not put there but is developed by the diastase of barley and long baking.

There results a food not only appetizing and very nourishing but an easily digested food which is of particular value where this factor must be taken into consideration in diet.

**Grape-Nuts,** unlike other cereals, requires no sugar. With milk or cream it makes a well balanced ration and withal is a wheat saver. It may be eaten with condensed or evaporated milk or cream where fresh milk or cream is not available, and its attractive form — crisp, nut-like granules, golden brown in color—makes it the selective food which many physicians find available at low cost in periods of illness and convalescence with both adults and children.

## At Grocers Everywhere

Samples of Grape-Nuts, Instant Postum and Post Toasties, for personal and clinical examination, will be sent on request to any physician who has not yet received them.

Canada Food Board License No. 2-026.

**Canadian Postum Cereal Co., Ltd., Windsor, Ont.**

P.—4

From another aspect, the rationale of vaccine treatment for chronic staphylococcal infections seems to be at fault. In these the protection against a new infection varies with the severity of the primary infection. In the case of a carbuncle the patient is protected against a new infection and the lesion generally remains single. In the case of a boil the protection is frequently of short duration, for often one or more boils appear before the first has disappeared; and cases of repeated crops of boils over months or years are common, or a continuous infection of fresh hair follicles occurs, as in *sycosis menti*. In these cases, in spite of the repeated stimulation of fresh infections, although there are intervals of improvement, yet the immunity reactions do not produce a cure. Why should we expect a vaccine to accomplish what the repeated reinfections fail to do? As a matter of fact, rarely, if ever, is a chronic staphylococcal infection cured by vaccines, and there is danger of ultimately making it worse by over-stimulation. Vaccine treatment is so uncertain that it has fallen into disuse almost equally with tuberculin treatment.—*Lancet—The Medical Review.*

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**Treatment of Vincent's Angina**

Among 225 men with sore throat sent to the contagious diseases hospital, Deglos (*Lyon Médical*) found 21 cases of Vincent's angina or "trench throat." The men were usually young, and the onset of the angina had been insidious. Bacteriological examination is necessary to diagnose the complaint properly: the fusospirillary organisms were present in all cases. Good results were obtained by repeated application of a 10 per cent. solution of methylene blue after clearing out the contents of the ulcer and swabbing with a solution of silver nitrate. In rebellious cases a single intravenous injection of neosalvarsan (0·3 gm. in 2 or 3 c.c. of double distilled water) led to a complete healing up in from four to six days.—*The Prescriber.*

# Appointments as Medical Examiners

The Empire Life Insurance Company of Canada has been formed under Dominion Charter with the special object of granting insurance to under-average lives.

## Ninety-Three Years' Experience in Sub-Standard Risks

The Clerical, Medical and General Life Assurance Society of London, England, was organized in Great Britain in the year 1824, with the same object that the Empire Life is founded to-day in the Dominion.

This company was in fact founded to grant life insurance to persons below the average standard of fitness imposed by the ordinary life offices of that day. By its Act of Incorporation, eight of the Board of Directors must always be members of the Medical Profession. The long list of eminent physicians and surgeons who have served in this capacity is a recital of the leaders of the medical profession in Great Britain during nearly a century. Sir Richard Douglas Powell, (Bt., K.C.V.O., M.D., Physician in Ordinary to H. M. the King), is the present Vice-President of the Society.

It is upon the broad lines which this great company has proved scientifically and commercially successful, that the Empire Life Insurance Company of Canada purposes to proceed, and thus extend in the Dominion the protection of life insurance to a large class from whom it has hitherto been withheld.

## Medical Examiners Appointments

Members of the Medical Profession are particularly invited to apply for full particulars as to appointments and investment.

**Managing Director, GEO. BOYD WICKES.**

**HEAD OFFICE - BANK OF TORONTO CHAMBERS**

**205 Yonge Street, Toronto**

# Selections

## A SIMPLE PHYSICAL METHOD OF INDUCING SLEEP

By G. King Martyn, M.D., Cantab, D.P.H.

Regarded from a public health point of view, the great drawback of the human body as a dwelling-house for the soul is the indisputable fact that the soil-pipe runs through the centre of the building. No modern architect would tolerate this for a moment. And yet it is difficult to see how else matters could have been arranged. It would hardly do for a man to walk abroad with yards of ilium and colon carried in a sort of marsupial pouch, much as the fashionable lady carries her marmoset or Pekinese in her enormous muff.

No—evolution has left the intestinal sewer there, and evolution generally knows. But on the top of evolution has come civilization. And by civilization I mean an age-long process of steady diversion of organs and habits from their right and proper functions.

Our intestines are going. The "dura ilia" are no more. Does anyone believe that pre-historic man suffered from gastric ulcers, duodenal ulcers, colitis, appendicitis, or Lane's kink? No—he never had any of them, and there were no surgeons to tell him he had them. *Tempora mutantur,* hence intestinal toxæmia and a host of other kindred devils.

Sleeplessness is due to many causes. The most fertile cause is irritation of the brain by messages from the abdomen. I would venture so far as to say that flatulent dyspepsia is the cause of nine out of ten cases of insomnia.

Take the earliest example—the infant "muling and puking in its nurse's arms"—keeping its careworn parents awake half the night. Why does rocking the cradle or "dandling" in the arms so often soothe and produce sleep? Because owing to the constantly changing axes of the loops of intestines the bubbles of wind are enabled to pass on. "The hand that rocks the cradle *moves the wind.*" Far better than "ruling the world"! For just the same reason the sleepless adult tosses on his bed from side to side. By so doing he involuntarily coaxes the

## Supplemental Feedings

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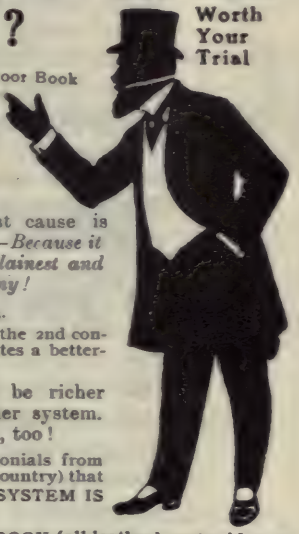

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flatulence to move on from loops of intestine, where it has been accumulating and sending those disturbing messages to the higher centres. And hence many a patient will sleep better after a dose of calomel or blue pill than after one of the recognized hypnotics.

Where is the chief accumulating place in the alimentary tract for wind to collect—in other words, where are the gas-works?

I am convinced it is the cæcum and that part of the colon below Lane's kink—the abdominal cess-pool. And by colonic stasis the ilium behind this part becomes dilated with wind.

The physical method I propose to overcome this impasse is stimulation of the bowel wall. If the patient has the necessary "Tactus eruditus" and the patience to carry out the instructions, he can quite well do it himself—otherwise skilled help must be employed. The technique is as follows: *First,* the patient lies on his back with the knees drawn up to relax any tension of the abdominal walls. Then the tips of all four fingers of the right hand are employed in gently "brushing the skin of the abdomen—barely touching it—and always in a circular direction. The movements should be begun low down below the umbilicus, and followed round to the iliac fossa, and then, following the course of the ascending colon, up to the costal margin. *Most time should be spent over the iliac fossa.* When the costal margin is reached the hand is moved again to the initial point and the manœuvres repeated again and again. *Secondly,* the whole of this process is repeated with the patient lying on his *left* side—the knee still drawn up. *Thirdly* and lastly, the same process is gone through with the patient in the final position for sleep—on his right side, the *left* hand being now used for the "brushing."

Some will say, "This is just abdominal massage." It is not. It is re-education of the nervous reflex and the muscular contraction of the bowel wall by stimulating the nerves of the overlying skin. In nine cases out of ten, after five minutes of this circular "brushing," borborygmi will be heard gurgling through the ilio-cæcal valve and passing up the colon. After a little longer wind will probably be passed per rectum. Sometimes these movements must be kept up for thirty minutes before a response is heard, and it may be necessary to include in the "brushing" not only the iliac fossa and the ascending colon, but the whole tract of the colon right round—remembering that the transverse colon sags like a washing line between its two

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posts. The manœuvres should be persevered with as long as any wind is heard to be moving, and then the patient will in all probability settle off to sleep.

Deep abdominal massage may be of use if there are impacted lumps of fæcal matter, but I believe harm is often done by too vigorous massage to a dubious appendix or gall bladder, and in such cases a high enema (or plombicus douche) is a better measure.

The writer hopes that some of his readers may be led to adopt this treatment, which, simple as it may seem, has often enabled him in many cases to consign barbitone, bromide, *et hoc genus omne* to the waste paper basket.—*The Medical Press.*

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One sometimes wonders what the attraction is which tempts young men to enter the profession of medicine. Certainly as a profession it is sadly underpaid (it has been estimated that doctors in America make on an average seven hundred dollars a year), so it can hardly be claimed that financial reward is the inducement; the doctor's life, too, at best, is one of hard and trying work, if not drudgery, so soft existence cannot be put down as the seductive influence. What then is the lode-stone?

In those who take up medicine as a serious vocation, I believe that it is the same intangible—inexplicable if you will—spirit that led a Livingstone into the heart of Africa, a Grenfell to the inhospitable shores of Labrador, and thousands of others into lives of useful and unselfish service to humanity.

Many apparently enter its ranks because medicine appears a genteel avocation; sometimes they wake up later to find that after all it is their true vocation; sometimes they drift along, poor derelicts upon a troubled sea, and never arrive.

It is interesting to note, however, that of the number of those who do become doctors, few ever forsake the profession for other pursuits. Of three hundred who were asked if they were satisfied with medicine, 225 replied in the affirmative, and only sixteen acknowledge that a mistake had been made and that the calling was not to their liking—Dr. W. P. Manton in addressing a graduating class.

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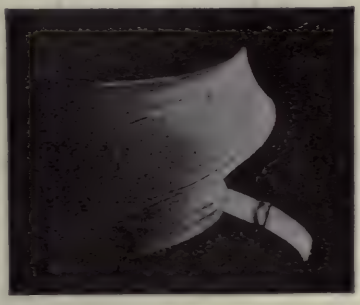

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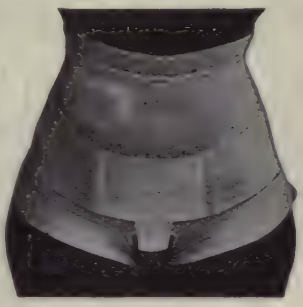

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# Miscellaneous

## Autumnal Ailments

The autumn months constitute the season during which the average practising physician is called upon to treat the following conditions: 1. Typhoid Fever, which is, more often than not, contracted at some unhygienic summer resort. The patient may return home during the first week or so, with headache, malaise, etc., or the premonitory or primary symptoms may appear after reaching home. 2. Malarial Infection, in certain sections, which is more than usually rife in the spring and fall seasons. 3. The after results of the gastro-intestinal disorders of infants and young children, due to improper feeding, etc., during the heated term. In almost every instance, when the acute symptoms have subsided, a condition of anæmia and general devitalization is the final result that constitutes the essential indication for treatment. In convalescence from all forms of illness resulting in general debility, Pepto-Mangan (Gude) is the one ideal tonic and reconstructive. It not only revitalizes the blood, but also tones up every physiologic function. It stimulates the appetite, improves the absorptive capacity, increases energy and ambition and restores the blood to its normal condition. It is, thus, a general tonic and reconstituent of marked and certain value.

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## Trinitrotoluene Poisoning

A. W. Gregorson and F. E. Taylor (*Glasgow Med. Jour.*, 1918) place on record five cases of "T.N.T." poisoning, two of which were fatal. Gastric disturbances and peripheral neuritis were the earliest symptoms, headache, anæmia, and jaundice following in the order named. The intensity of the jaundice varied from week to week, and it was noticed that as the color faded the patients showed signs of improvement. The treatment recommended is as follows: Absolute rest in bed and warmth are essential. *Diet*—Milk, with 5 grains sod. bicarb. to the ounce; 6 ounces to be given every two hours. Tea or coffee, *ad lib.* Benger's food, milk pudding, virol, imperial drink, barley water, albumin water, fish, rabbit, vegetables, but all excess must be carefully avoided, and fatty and

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saccharine foods prohibited. There must be a free exhibition of alkaline beverages to counteract the tendency to acid intoxication. *Medicines*—Calomel, 2 grains, followed by saline eight hours later; and the bowels regulated with cascara sagrada and sodium sulphate. To correct intestinal acidity it is best to prescribe an insoluble alkaline carbonate such as magnesia. A mixture containing potassimum citrate, sodium bicarbonate, and sodium sulphate should be given every four hours. Later, the patient may be given a mixture containing potass. bicarb., tinct. zingib., tinct. rhei co., and infus. gent. Rectal salines, with sod. bicarb. 2 ounces to the pint, may be given every six hours. Intravenous or subcutaneous saline injection, when the patient is first seen, gives great relief, and inhalation of oxygen through warm ether is a valuable stimulant.—*The Prescriber.*

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## A Forgotten Physician of the Second Century

Samuel, surnamed Schabour, and also Arioch, and mentioned in Jewish literature as Mar Samuel, was born at Nehardea (destroyed by Odenathus in A.D. 259) about A.D. 160. His father, Abba, was an important person there. Physically insignificant, being abnormally short and ill-developed, intellectually Samuel was great. He was educated at Nehardea by Rabbi Leir, a learned man who turned out several famed pupils. Samuel studied and specialized in various branches of learning, but his chief reputation and, indeed, the profession he finally made his own was that of the healing art. As a student he early made such progress in medicine that he was permitted to perform autopsies, and we have records of some of these. There is an account of a decision of his as to how large a piece of skull could safely be removed in case of fracture. He is quoted as stating after examination of an aborted fœtus that it was 41 days old, showing an intimate knowledge of the conformation of the product of conception at various stages. His opinion upon the abnormality termed spina bifida is also upon record. He must have carried out anatomical dissections, because there are extant quotations from his views on the limit of the spinal marrow. He appears to have been cognizant of the lachrymal gland and of the atrophy of which it is susceptible under certain circumstances in advanced age. His treatise upon the pathogenic symptoms following upon abrupt changes of diet is quite modern in thought.

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For external diseases he sought natural causes for their occurrence and for their fatal termination; so for penetrating sores he accused the air of rendering them incurable. Also for wounds which finally poisoned the system, he said the cause was some virus upon the weapon that had inflicted the injury. In pathology he endeavored to indicate for each malady the characteristic symptoms: for grave rhinitis, following probably a polypus ulcer, he said it could be detected by the offensive odor proceeding from the nasal organ. Migraine he attributed to excessive solitude and introspection. Magic as a curative he ignored. As to the propriety of attempting cures upon the Sabbath he was entirely favorable. He advocated the use of speculum in order to ascertain if hæmorrhage proceeded from the vagina or the uterus. Cleanliness was a main feature of his preventive teaching. The hands should be washed at least twice a day to prevent eye affections. He admitted his inability to cure three illnesses: that proceeding from eating green dates, if unripe and sour; the evil consequences of wearing a damp linen waistband as a girdle; and illness caused from going to bed after eating too hearty a meal and taking no exercise.—*The Lancet.*

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**Female Sterility**

T. C. Stelwagen, M.D., and P. S. Pelouze, M.D., Philadelphia. *Journal of the American Medical Association.* While valuable work has been done on the bacterial flora of the female genitalia, little appears to have been done as regards the possible effects of such flora on procreation. The authors report a case of a woman who had been under the care of an eminent gynæcologist for a year and a half, for the purpose of correcting an apparent sterility without effect, though her husband's seminal fluid contained countless numbers of very active spermatozoa. There was complete absence of vaginal discharge. The cultures taken from the vagina showed the usual flora with the predominance of diphtheroids, while those from the cervical canal were purely diphtheroids, showing almost all of the Westbrook types of diphtheria bacillus, with many striking metachromatic forms. Autogenous vaccines were made and used on the husband and wife. This caused the disappearance of the diphtheroids. Three months later she found herself pregnant, and later gave birth to a healthy girl baby.—*American Journal of Surgery.*

# The Canadian Practitioner and Review

Vol. XLIII. TORONTO, DECEMBER, 1918. No. 12

## Original Communications

### THE RECENT INFLUENZA EPIDEMIC

JOHN HUNTER, M.B., TORONTO.

EXPERIENCE.

The recent epidemic—so widespread and so direful in results—presented many intensely interesting features, some of which were unique. It was unique in its ubiquity. Most epidemics travel along well-defined routes—oceanic or transcontinental. This epidemic seemed to come from nowhere, and to spread everywhere it could find victims to attack. It also specialized in its choice of victims. The very young and those past mid-life did not seem to furnish good culture mediums, and were comparatively immune. The incubation period was exceptionally brief. The physician had scarcely left the house of his patient when a call was sent to his office for him to go back, and see about all the others in the household who were susceptible to infection.

Where there were two or three generations living in the same house, all "were down" save the grandfather, or mother, and the youngest grandchildren. Boarding-houses were veritable hospital wards.

The onset and course of the disease were remarkably uniform. Quite suddenly there appeared a more or less marked hyperæmia of the respiratory tract—nose, throat and bronchial tubes. A temperature range of 101-104 and a rather pronounced feeling of exhaustion. Patients seemed very willing to go to bed. Nasal hæmorrhage, an irritable cough, gastric disturbances, pain in nerves, joints, and muscles were the more

frequent complications. Psychic perturbations were very little in evidence. In the writer's experience, patients with cardiac lesions and those who had been the victims of empyema, nephritis, biliary calculi, cystitis *et al* suffered as little, sometimes less, and recovered as quickly as those who had always enjoyed normal health. It took a heavy toll on the pregnant and on those in labor, or who had been recently confined.

In regard to the frequency of pneumonia, there is rather a striking conflict of opinions. Some claim that it was present in many of their cases, whereas other equally competent observers found it in less than one per cent. of their cases. The latter attributed all the symptoms they found to the effect of an acute hyperæmia of the respiratory tract. These based their diagnosis on the absence of the classic symptoms of pneumonia, and on the rapid recovery of their patients. The writer examined every chest as thoroughly as time permitted, and could not verify a diagnosis of pneumonia in even one per cent. of his cases, and the mortality was less than one per cent. of all the cases. There were only two deaths, and both from pneumonia. One was seen once by his lodge doctor during the first four days of his illness, and the other had an abortion on the sixth day. In none of the other cases—some two hundred and sixty or seventy—were there any serious complications, or any protracted illness. The average time in bed was less than four days.

### Treatment.

All the sunshine possible. Patients were promptly removed to the "sunniest" room in the house. Windows widely opened, day and night. Poultices and pneumonia jackets strictly prohibited. Face, neck, arms and chest bathed frequently with cold water. Night and bed clothes changed often. Never disturbed during sleep. A glass of milk, containing a teaspoonful or two of milk of magnesia, as a mild laxative, four or five times a day. Cereals, vegetable broths. Many glasses of water.

The ordinary doses of the "coal-tar" preparations early abandoned, especially on account of the danger to which the patient was exposed in changing the clothing saturated with perspiration. One grain doses of the following five drugs—quinine hydrobrom, camphor monobrom, guaiacol carb, acid acetyl-sal, and caffein. cit.—combined as needed, seemed to answer all purposes most satisfactorily. Anodynes, etc., prescribed as needed.

Serums were not used in any case. One very degenerate serum-enthusiast—unknowingly to the writer—gave my patient, who, at the time, had no unfavorable symptoms, an injection of serum. The next day the arm was inflamed from shoulder to wrist, and greatly swollen. The wife said, "My brother-in-law sent his doctor to give the serum." She refused to give the degenerate's name, and any further attendance ceased. A few days later the funeral notice appeared. The writer saw quite a number of acutely inflamed arms from serum injections, and at a recent meeting of the Academy of Medicine all that could be said was, "That the use of serum was still in the experimental stage." Whether it is of any use or not remains to be proven, but no condemnation can be too strong for the unethical and dishonest way in which its use was propagated. Some hyper-enthusiastic, or perchance deluded serum-vendors, actually solicited casual acquaintances to allow them to give a hypodermic as a prophylactic. The doctor got a two, three, or five dollar fee, and subsequently the patient got an inflamed arm and a more or less severe attack of influenza. This solicitation for victims became common enough to create a suspicion amongst the laity that serum was being exploited for mercenary purposes.

### Impressions.

It soon became apparent that the psychic factor was at least equally potent with the scientific one in curing the patients. The mental relief afforded by the visit of the physician was very great. The assurance that there were no complications seemed to completely change the patient's attitude toward the disease.

The amount of work done by physicians who are in the latter half of the sixth, in the seventh, and even in their eighth decade was most amazing. Old age seemed no handicap at all. It was the younger men who first showed symptoms of fatigue. Is it their morbid addiction to the cigarette that made them show up so badly in a contest with veterans? Again, why should men in mid-life exhaust their vitality in attempts to outstrip their competitors? One of the saddest tragedies in the aged physician's life is having to attend the funerals of so many far younger men.

### The Menace of the Automobile to Professional Efficiency.

The writer for a time was—like nearly all of his confreres—under the "delusion" that the "auto" was a real necessity. He soon found that he was getting more patients than any one man could attend to properly; and, worse still, the "auto" robs one of that mental relaxation and exhilaration experienced in walking. He had to abandon the "auto" or else have the average high mortality.

# Editorials

## THE BASE HOSPITAL, TORONTO

In regard to conditions at this military hospital, we desire to make a few statements of interest from a medical standpoint.

The building (old General Hospital) was not quite satisfactory in several respects; but it was in every way quite as good, and, in some ways, better than St. Andrew's College (another "used up" building).

Much satisfaction was expressed when the statement went out that the sick soldiers were removed to the *superior* new Rosedale Military Hospital; and yet, at the time of writing, some weeks after this much heralded removal, there is not a single patient in any of the new buildings which are being erected.

As a matter of simple justice to an exceedingly competent and thoroughly conscientious medical staff we desire to say, after careful investigation, that from a medical point of view, the management was good, the patients were well cared for, with treatment in all respects skilful and quite up to date. Those competent to judge, who know the methods employed, say there was nothing better in any military hospital in the British Empire. In times of stress in any hospital it is difficult, sometimes impossible, to accomplish all one would desire, but we believe the staff of the Base Hospital did wonderfully well under very difficult circumstances, and we know

that a goodly proportion of its members during the busy time worked and overworked with a devotion beyond all praise.

The value of statistics may be limited, but we give the following figures: Total number of influenza cases in Toronto Base Hospital, 1,800; mortality, 3.9 per cent. Total number in military hospitals of the United States not given, but mortality up to Nov. 1, was 5.6 per cent. The mortality rate in the General and Grace was much higher, but the circumstances were so far different that a comparison is useless. It is worth mentioning, however, that the mortality from pneumonia at the Base was 32 per cent., while that at the General (excluding cases of death within twenty-four hours after admission) was 43 per cent.

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## THE BLINDED SOLDIER

Eugene Brieux, of the French Academy, has written regarding the blinded soldiers of France. He says: "The first thing to bring home to the blind man is that he can still be happy, chiefly through attaining self-confidence and the desire for independence. It must be urged that they will soon be able to get along without help from others' eyes, and that the law of compensation works within their being, developing other senses to make up for the one that has been lost." He deals on the practical side with possibilities of occupations, and, having in view the love of the Frenchman for *la terre*, considers especially farming as a pursuit for the blinded

soldier. One such, in a letter full of bravery not less than the bravery of the battlefield, admits that he once said: "It is easy for M. Brieux to talk; I should like to know what a man can do that cannot see." Later, having been trained by himself and others in self-confidence, he admits that he could never have believed he could be as contented as he is now, feeding his beasts and digging his beets and his potatoes. The blind themselves pitch the note for their sympathisers. Hope and confidence they seek, but no pity. Some French blind schools display on their walls the warning: "To pity is not to console."

## CANADA IN THE WAR

It is supposed that there were about 55,000 Canadians killed and over 150,000 wounded in the war. General Mewburn stated, Nov. 25, there were in England, 40,000 women and children relatives of soldiers; and, in addition, there were over 2,000 widows of soldiers, a large portion of whom have never seen Canada. No one appears to have any idea as to the number of the latter who will desire to come across the sea. We are told, however, that those who come will receive a hearty welcome from the friends of their dead husbands.

## MEMORIAL HOSPITAL FOR ELGIN COUNTY

At a meeting of the Elgin County Council held Nov. 22, it was decided, in accordance with the wish of the City Council, that the county would co-operate with the city, and it is now expected they will build a hospital as a memorial to the fallen heroes of the County of Elgin and the City of St. Thomas.

# C.A.M.C. News

### Canadian Siberian Force.

A.D.M.S., Col. J. T. Clarke, C.A.M.C.; D.A.D.M.S., Major T. Morrison, C.A.M.C.

### 16th Canadian Field Ambulance.

Lt.-Col. C. A. Warren, Majors G. A. Winters, W. M. Carrick, Capt. C. A. Marlatt, Lieuts. S. A. Wallace, W. G. Bowles, M. C. Adamson, G. C. Kenning, H. W. Elkington, H. E. Skeete, R. R. Struthers; Capt. W. J. Warden (Q.M.).

### 11th Canadian Stationary Hospital.

Col. J. L. Potter; Major F. A. Cleland; Capts. F. J. Scully, J. F. C. Colling, J. H. Box, G. L. Sparks, W. T. Kennedy, A. M. Savoie, G. H. Lansown, N. Morin, J. Race; Lieuts. J. M. Munro, H. C. Connell, H. H. Potts; Capt. H. Barratt (Q.M.).

### Regimental Medical Officers.

Capts. J. L. King, H. R. Holme, V. H. McWilliams, A. J. Shilistra, W. R. Scott, W. G. Shepherd, L. M. Stuart, C. W. Moore.

### Advance Depot Medical Stores.

Hon. Capt. J. W. Jefferson.

### Sanitary Section.

Capt. H. W. Lewis.

### Returned from Overseas.

Cols. F. G. Finley, L. E. W. Irving; Lt.-Cols. J. C. Meakins, T. A. Starkey, C. S. McVicar; Major W. Creighton; Capts. A. B. Greenwood, H. C. Pearson, W. E. Struthers, C. L. B. Stammers, J. W. McIntosh, W. R. Coles, G. H. Wade.

### Struck Off Strength.

Lt.-Col. D. McGillvray; Capts. W. H. Taylor, W. E. Struthers, T. B. Ramsay. B. C. Reynolds, Capt., resigns to join the Invalid Soldiers' Commission.

### Promotions, Overseas.

Major-General G. L. Foster becomes Director-General Medical Services, C.M.F.C. Col. A. E. Ross becomes Brigadier-General and D.M.S., Canadian Section, at G.H.Q. Majors J. M. Nettleton, S. R. Harrison, D. A. L. Graham, C. Hunter, become Lt.-Cols. Capts., A. B. Schinbein, J. E. Campbell, A. Blais, H. O. Boyd, H. W. Wookey.

### Promotions in Canada.

Capt. W. J. Chapman to be Major while D.A.D.M.S. at Winnipeg.

### Nursing Sisters.

The following have been struck off the strength for various reasons:—Nursing Sisters J. A. McArthur, M. Reveler, A. Chisolm, A. E. Shipman, F. B. Buck, J. Thompson, E. G. Mitchell, M. H. Langman, K. A. Cole, G. F. Bliss, H. M. Wilson, E. Champagne, E. J. Fraser, M. M. Wilson, A. L. McPhee, A. B. Stover, F. I. Stewart, E. O. Holland, M. V. Miller.

### Returned from Overseas.

Nursing Sisters M. M. Parker, L. M. Baillie, V. H. Keene, M. H. Langham, E. Holland, R. Carmichael, Matron M. Goodeve, C. S. Leachy, Y. Doucet, M. A. Scriver, L. M. Mabee, A. M. Cameron, E. E. Lumsden, A. Chisholm.

### Appointments.

Col. L. E. W. Irving replaces Lt.-Col. Ryerson as A.D.M.S. at Toronto. The latter retires to assume his duties at Toronto University. Lt.-Col. McVicar becomes Senior Physician at Spadina Military Hospital. Lt.-Col. O. A. Cannon replaces Lt.-Col. Grant as A.D.M.S. at London. Major J. J. Ower becomes Pathologist to Ste. Anne Military Hospital. Capt. H. R. Mustard becomes D.A.D.M.S. (Hospitals) at Vancouver.

# Personals

Dr. Sylvester, of Toronto, left for California.

Dr. W. R. White, of Baltimore, visited Toronto, November 26.

Dr. Leslie Coleman, Bangalore, India, visited Dr. Minns, Toronto, November 13.

Dr. James Roberts, M.O.H., Hamilton, was married to Miss McBeth, October 26.

Dr. Helen MacMurchy addressed the Y.M.C.A. in Ottawa, November 22, on Reconstruction.

Dr. Gilbert Royce (Lieut.-Col.), returned from overseas November 8. We are pleased to report that he brought with him an English bride.

Walter B. Swift, M.D., of Boston, has been appointed Consultation Expert for Speech Defects to the Division of Medical Inspection of the Public Schools of Cleveland, Ohio.

The memorial to Dr. Young in Kew Beach is not yet erected, but at a meeting held November 7, arrangements were made to have work completed as soon as possible.

Dr. C. W. Service, Superintendent of the Men's Hospital, Chengtu, China, is back in Canada on a furlough. He says that the present epidemic of influenza originated in China some time before it appeared in Spain.

# Obituary

## ROBERT McCLURE, M.D.

Dr. McClure died suddenly at his late residence, Port Elgin, October 25, aged 88.

## J. A. JOHNSTON, M.D.

Dr. Johnston, who graduated in 1910, died at his late residence, Stayner, October 26, of pneumonia, aged 34.

## JOHN C. McCABE, M.D.

Dr. J. C. McCabe died at his home, Hamilton, November 14, aged 63. He graduated from Trinity University, in 1886.

## SUSAN L. FOTHERINGHAM, M.B.

Dr. Susan Fotheringham, of Toronto, died of pneumonia, November 12, at the Women's Christian Medical College, India.

## ROBERT WALTER MUNRO, M.D.

Dr. Munro, who graduated in 1912, died at his late residence, Smithville, of pneumonia, October 26. His wife, Winnifred Munro, died of same disease, October 28.

## ANDREW ROSS, M.B.

Captain A. Ross, who graduated from Toronto University in 1915 went overseas last year. His death was reported early in November.

## R. W. FAULDS, M.D.

Dr. Faulds, of Elmira, Ont., died October 28, at his home, of pneumonia, aged 37. He had practised in Elmira for five years.

## W. C. SWENERTON, M.D.

Dr. Swenerton, a prominent surgeon of Vancouver, died of influenza, October 25, aged 31. He was born in Exeter, Ont., and graduated from the University of Toronto in 1911.

## T. R. GUILFOYLE, M.D.

Capt. Guilfoyle (C.A.M.C.), died in Witley Camp, England, October 28. He graduated M.D. from the Western University, and, prior to enlisting in 1916, practised in Belgrave, Ont.

## NEVILLE H. LITTLE, M.D.

Dr. (Captain) N. H. Little, who graduated from Toronto University in 1916 and went overseas with the 13th Canadian Field Ambulance, is reported to have died of wounds received, November 4.

## ALBERT W. STINSON, M.D.

Dr. A. W. Stinson died October 29 at his home in Cobourg from influenza, which carried him off in a very short time, because he was much reduced in strength from overwork in his profession. He graduated from Victoria and Toronto Universities in 1888.

## ELISHA JESSOP, M.D., M.P.P.

Dr. E. Jessop, of St. Catharines, died at his home, October 24, aged 75. He graduated from the University of Toronto in 1876, and practised for many years at Jordan before moving into St. Catharines. He was very popular in his district, and was the representative for Lincoln County in the Ontario Parliament for twenty years.

## WILLIS A. SARGENT, M.D.

Dr. W. A. Sargent died at his late residence, Colborne, of pneumonia, Oct. 28, aged 53. He graduated from Trinity University in 1891, and, after practising in Springbrook for seventeen years, removed to Colborne, where he soon acquired a large practice. He was an admirable general practitioner, and was very highly respected in Northumberland County.

## JAMES L. STAPLETON, M.D.

Dr. Stapleton died at London, Ont., November 1, of pneumonia, aged 32. He graduated M.D. from the Western University. After doing some work in Buffalo and in the Hospital for Insane, Hamilton, he commenced practice in London. He was considered one of the brightest young practitioners of that city, and his death is deeply deplored.

## E. K. HENDERSON, M.B.

Dr. Henderson, formerly of Toronto, a practitioner of Haliburton, died at his home, November 26, of pneumonia, aged 31. His brother, Dr. James Henderson, is reported to have died of pneumonia recently, after having served with the fighting forces in Flanders and Mesopotamia.

## P. R. SHANNON, M.B.

Lieut. Shannon went overseas during his medical course. He returned to Toronto to complete his medical studies in 1916. After receiving his degree he again went overseas. His aunt, Mrs. Adam Lind, received an official message saying he died of wounds in France, November 4.

## R. S. BREWSTER, M.B.

Dr. R. S. Brewster, a practitioner of Beeton, Ont., for fifteen years, was killed by an automobile accident, November 26. While making his round of professional calls his car turned turtle, and pinned him to the ground. When released a few minutes after life was extinct. Dr. Brewster, of Owen Sound, is his brother.

## WILLIAM FRANKLYN LUTON, M.D.

Dr. W. F. Luton died in Bristol, Eng., October 28, of pneumonia, aged 29. He graduated from the Western University, and after practising one year at St. Thomas, went out to British Columbia, where he practised a few years. He enlisted in Vancouver and was made a captain in the A.M.C. last year, and went overseas in September of this year.

## JAMES B. RUTHERFORD, M.D.

Dr. James Rutherford died at his home in Chatham, October 24, after an illness of about four weeks, aged 74. He graduated from Victoria University in 1867 and continued in active practice for a few years at McKay's Corners. Then he practised in Chatham until last February, when he retired. He leaves two sons in the profession, Dr. James W. and Reg. W., both practising in Chatham.

## NORMAN H. BEAL, M.D.

Dr. Norman Beal, of London, Ont., died at Rochester, Minn. He graduated in 1908 from the Western University ten years ago, and soon after commenced practice in London, devoting himself especially to certain branches of surgery. Early in October he removed to Rochester, where he engaged to practise surgery with the Mayo Brothers in the hospital for one year. Shortly after he reached that city he contracted influenza, and died of pneumonia October 27.

## JAMES F. BOYLE, M.D.

Dr. J. Boyle, formerly of Elora and Toronto, died at Edmonton, Alberta, October 29, of pneumonia, aged forty-six. He was the son of the late Dr. David Boyle, for many years the Superintendent of the Provincial Museum in Toronto. Dr. J. Boyle graduated M.B. from the University of Toronto, and shortly after served for a time in the South African War. He then did post-graduate work in Edinburgh and Glasgow, and on his return to Canada practised for five years in Priceville, Ont. After leaving that town he went to Edmonton, where he practised for eleven years with signal success.

## WILLIAM THOMAS LITTLE, M.D.

Dr. W. T. Little, who graduated in 1914, commenced practice in Flesherton. He went overseas and served as captain in the R.A.M.C. in Mesopotamia for fourteen months. His health was poor for a time after his return, but he appeared to be recovering when he contracted influenza and died at his father's residence in Owen Sound, November 2.

## ARTHUR ALLAN PARKER, M.B.

Captain A. A. Parker died of wounds received shortly before the armistice was signed. He graduated from the University of Toronto in 1914. After acting as an interne in the H.S.C. for a time, he served at the Stationary Hospital at Exhibition Park before going overseas. He was awarded the M.C. for gallant conduct in the field, November 9, 1917.

## ANDREW ORR HASTINGS, M.D.

Dr. A. O. Hastings died at his late residence, Toronto, November 21, aged 64. He had for many years a very large practice, which at times taxed his strength greatly. The death of his wife, more than a year ago, was a tremendous blow to him, coming at a time when he did not appear to have strength to rally from its effects. Very few, however, knew how really serious his condition was; and the report of his death caused much surprise and sorrow among his many friends.

Dr. Hastings graduated M.D. from Victoria University in 1886; and, after doing post-graduate work in Great Britain he commenced practice in Toronto, and soon achieved pronounced success. As a man he was honorable and trustworthy; as a physician he was kind, skilful and devoted to his work. He loved his patients, and was greatly beloved by them. He was one of the best specimens of a good, kind, and useful general practitioner. Dr. Charles J. Hastings, M.O.H., Toronto, is his brother.

## KENNETH MACKINNON, M.B.

Dr. Kenneth MacKinnon, of Guelph, only son of Dr. Angus MacKinnon, died of pneumonia, October 30, aged 41. He graduated M.B. from the University of Toronto in 1901, and passed his final examination before the Ontario Medical Council in 1902. After some post-graduate work he commenced practice in Guelph, and was successful. Overwork affected him to such an extent that influenza soon ran into a virulent pneumonia, which caused his death in a comparatively short time.

## SUB-LIEUT. J. D. GEAR.

Sub-Lieut. J. D. Gear, son of Dr. Henry Gear, Erin, Ont., a student in medicine in Toronto University, after completing his third year, went overseas to join the navy. After receiving his commission he got a short "leave," and while on shore was suddenly taken ill and was removed to Third General Hospital, Eng., where he soon died, November 10.

Roy E. G. Henry, No. 5 Company, McGill University reinforcements, Princess Patricia's, son of Dr. S. M. Henry, Toronto, formerly Harriston, Ont., was killed in action in France, September 28.

Dr. J. Hillyard Robinson, a resident of Toronto before graduating in medicine from Trinity University, died in Cleveland, Ohio, November 8.

Mrs. Parsons, wife of Richard Parsons, M.D. (Trin., 1902), F.R.C.S., died at her home, Red Deer, Alta., of pneumonia, November 28.

Mrs. Lauder, daughter of Dr. D. S. Hoig, Oshawa, died of pneumonia, November 7.

# Correspondence

Dr. J. H. Elliott has written to me under date Nov. 12. In his letter I find the following: "Although I do not know what the intentions of the committee were as regards the treasurership, I placed in their hands my written refusal to accept re-nomination as treasurer, pointing out that it had been a rule in the past for the treasurership to be held not more than three years, while I had held it for five years, and I felt strongly that the office should be passed on to someone else in the profession."

In a brief conversation Dr. Gibb Wishart told me Nov. 21 that he had a large part in the work done in connection with the preparation and management of the Hamilton meeting. I supposed he wished me to understand that he generally approved. I had not understood this and I was sorry and surprised. Otherwise I have no comments to make. A. H. W.

# Selections

## GRIP OF GERMANY ON MANY INDUSTRIES

FEDERAL INVESTIGATIONS ALWAYS SHOW SAME GROUP.—DRUG, CHEMICAL AND SURGICAL INSTRUMENT BUSINESSES WERE ESPECIALLY SOUGHT BY GERMANS—RICHARD KNY APPEARS TO HAVE BEEN VON BERNSTORFF'S FAVORITE.

A comparison of revelations made by the office of A. Mitchell Palmer, alien property custodian, covering a period from the time America entered the world war until the present shows a startling repetition of certain names among those representing German interests. These revelations have come at considerable intervals, so that only by a close comparison of the names involved does it become clear that the trail of the Imperial German Government left here by former Ambassador von Bernstorff, usually revolves around the same group. A name often mentioned in these revelations is that of Richard Kny. Kny is a well-known Brooklynite, living at No. 237 Garfield Place. He was born in Germany, but is a naturalized American citizen and the father-in-law of George Simon, an enemy alien, who was manager of the Heyden Chemical Works at Garfield, N.J., until they were seized by the alien property custodian.

It is said in authoritative circles that the work of unraveling the connections of Kny and his attempts to control the drug, chemical and surgical instrument business in the United States have been far more interesting and absorbing than any detective fiction ever written. The facts in Kny's case are said to have far outstripped the imagination of any literary dreamer in working out international plots and situations.

The four principal companies in which Kny has been found to be either the head or heavily interested are the Heyden Chemical Works, Garfield, N.J.; Eiseman Magneto Co., New York; Kny-Scheerer Co., New York, and the Chemical Exchange Association, the last-named being the camouflage de-

vised by Kny and Dr. Hugo Schweitzer to control the carbolic acid supply of the United States and prevent it from going into the manufacture of munitions to be used against Germany. The official revelations in connection with this last-mentioned concern were made public by Mr. Palmer on October 18th.

The cunning and secret work of Kny and his associates was so well covered up that only the most careful work on the part of Mr. Palmer's assistants succeeded in uncovering it. The question which now interests the drug, chemical and surgical instrument trade is whether or not other companies will be found to be the property of the same crowd of aliens with which Kny was associated and which are believed to be responsible for the long list of explosions, burnings, ship sinkings and other outrages which have infuriated the people of the United States nearly every week since the war began.

The Kny-Scheerer Corporation, one of the biggest dealers in surgical and electro-medical instruments, scientific apparatus, hospital and sanitarium supplies in the United States with offices at No. 404 West Twenty-seventh Street, New York, used the identical trade-mark as the Jetter & Scheerer Co., of Tuttlingen and Berlin, Germany. This trademark appears on the letter-head of the Kny-Scheerer Corporation and appears in the advertisements inserted in German technical publications by the Jetter & Scheerer Co., of Germany. Official investigation has shown within the past few days that both of these companies are still using this trademark.

The Kny-Scheerer Corporation had the exclusive American agency for the products of its parent concern, the Jetter & Scheerer Co. The German concern claimed to be controlled by the German Government and E. S. Beck, its secretary, until Mr. Palmer seized the company, was a brother-in-law of the Scheerer who owned most of the parent concern. This Scheerer's wife is said to be a close relative of Count von Buelow, the well-known Teuton official.

Evidence now in the hands of the alien property custodian shows conclusively that the Imperial German Government, through careful investments made by Ambassador von Bernstorff in this country, tried and almost succeeded for a time in controlling the drug, chemical and surgical instrument business of this country and imperilling the supplies of these articles required by the army and navy of the United States. It is believed the master brains who advised von Bernstorff and Dr

Albert, the official German go-between, were Dr. Hugo Schweitzer, former chemist of the Bayer Company, and Richard Kny.

The cleverest deal with which Kny has so far been connected by Federal officials is that which was put through in the case of the Heyden Chemical Company. This concern has an office at No. 135 William Street, Manhattan, and a large plant at Garfield, N.J. It was owned for many years by the Chemische Fabrik von Heyden, of Germany, and was managed by George Simon, son-in-law of Richard Kny. When the Government seized this plant some weeks ago, it was found that an elaborate effort to disguise the German ownership had been made by Simon. The company was an exceedingly prosperous one, and in 1917 did a business in excess of $4,000,000. The profits sent to the German owners in 1916 were $1,026,626.

When Francis P. Garvan investigated this deal for Mr. Palmer, he discovered Simon had obtained $149,000 in cash from his father-in-law at the time of the breaking of relations between the United States and Germany with which the German owners were alleged to have been bought out. This deal was knocked in the head by the action of the Government in seizing the plant and preparing to sell it to owners known to be real Americans.

While Federal officials in touch with developments in the investigation into Germany's hold on the American drug, chemical and surgical instrument business refuse to make any comments in advance of official announcements, it is plain that further disclosures are expected regarding the chain of industries over which von Bernstorff gained an evil sway. In view of the uniformity with which the same group of men were used by him in putting through the deals already uncovered by Mr. Palmer's men, there is little reason to doubt that the same agents will be found to have been used in the deals which are known to have been made, but which have not yet been officially announced. In the meantime, the drug and affiliated lines are looking forward with a good deal of interest to the result of the investigations now under way.

## ONE NON-ESSENTIAL INDUSTRY

The question as to what constitutes a non-essential industry in war-time cannot be answered offhand. The complexities of modern business are such as to make it extremely difficult to determine just what industries should be suspended under the stress of war conditions without inflicting a greater economic injury than is justified by the possible benefits that might accrue. There is one business, however, that those who have given the problem any study would have to admit should be largely dispensed with during the war—and might properly be largely dispensed with at all times—and that is the manufacture of nostrums. Every physician and every druggist knows that there is not a "patent medicine" on the market to-day whose place is not better filled by official products that are found on the shelves of every druggist in the country. Every physician and every druggist knows that the "patent medicine" maker aims, not to furnish drug products that can be obtained in no other form, but to duplicate in infinite variety, with secret mixtures, the non-secret preparations already on the druggists' shelves and, what is far worse, to stimulate unnecessary self-drugging on the part of the public. It is true that, if the "patent medicine" industry were destroyed, druggists would for a while suffer financial loss, not because they derive a large profit from "patent medicines," but because the public, being deprived of the lying scare-heads of "patent medicine" advertisements, would buy fewer drugs of every kind. Certainly, however, this loss to some thousands of druggists would be an immeasurable gain to some millions of people. The exploiters of a widely heralded nostrum have bragged in their advertisements of the number of carloads of their mischievous alcoholic mixture that they have shipped to certain points. Does even the intelligent layman believe that under present conditions there is any excuse for taking up valuable shipping space with such worthless, if not dangerous, trash? And this is but one of the scores. If there is one industry in the United States whose suspension at the present time is justified on the grounds of public health, greater efficiency and avoidance of waste, it is the nostrum industry.—*Jour. A.M.A.*

# Coffee Drinking Dissipates Energy

Any article of diet taken into the system which acts as a "whip" to flagging energy is but temporary in its ***apparent*** benefit. In the end, it ***subtracts*** from the ***total energy*** of the individual. This, in the case of Coffee, is a manifestation of the law of alkaloidal "action and reaction," caffein being the alkaloid in coffee.

The temporary ***feeling*** of increased energy, after having taken the usual cup or two of coffee is, in a large majority of individual cases, soon followed by a feeling of lassitude which more than counter-balances the temporary spurt of ***artificially*** aroused activity of mind or body. Hence, we may truthfully affirm that, in summing up its effect, coffee-drinking dissipates energy.

On the other hand—

# POSTUM

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P.—4

# Miscellaneous

## The Pneumonia Convalescent

In spite of all the modern advances in scientific therapy, and the improvements in the general handling and management of acute infectious diseases, Acute Lobar Pneumonia still deserves the title ascribed to it by Osler: "The Captain of the Men of Death." There are, however, especially during the Fall and Winter months, many cases of the lobular or irregular Pneumonia that so often complicates or follows La Grippe. When this condition supervenes it is more than likely to follow a sub-acute or chronic course and convalescence is frequently long delayed. Under such circumstances, in conjunction with treatment designed to hasten resolution, a general blood tonic and vitalizing agent helps materially to shorten the convalescent period. Pepto-Mangan (Gude) is of much value in this field, because it not only increases the solid elements of the blood, but also acts as a true tono-stimulant to the organism generally. As Pepto-Mangan is free from irritant properties and constipating action, it is especially serviceable in the reconstructive treatment of the devitalization following the Pneumonia of the aged.

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This company was in fact founded to grant life insurance to persons below the average standard of fitness imposed by the ordinary life offices of that day. By its Act of Incorporation, eight of the Board of Directors must always be members of the Medical Profession. The long list of eminent physicians and surgeons who have served in this capacity is a recital of the leaders of the medical profession in Great Britain during nearly a century. Sir Richard Douglas Powell, (Bt., K.C.V.O., M.D., Physician in Ordinary to H. M. the King), is the present Vice-President of the Society.

It is upon the broad lines which this great company has proved scientifically and commercially successful, that the Empire Life Insurance Company of Canada purposes to proceed, and thus extend in the Dominion the protection of life insurance to a large class from whom it has hitherto been withheld.

## Medical Examiners Appointments

Members of the Medical Profession are particularly invited to apply for full particulars as to appointments and investment.

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During the past few years the business of the company has grown so rapidly, that it has now been thought desirable, to convert the business into a joint-stock company. This company has been fortunate in securing the services of Mr. Thos. J. LeCras and of practically the entire staff connected with the business.

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The company has also taken over all the patents, trade-marks and special processes connected with the business, so that customers of the new company will be able to still obtain artificial limbs and trusses possessing distinct advantages over similar goods turned out by United States or Canadian manufacturers.

Although the business is growing very rapidly and it may be necessary to secure larger premises, we beg to advise our customers generally, that the company will, for some time, continue to carry on business at the old stand, namely, 135 Church Street, Toronto.

Yours very truly,

AUTHORS & COX LIMITED.
THOS. J. LeCRAS, *President.*

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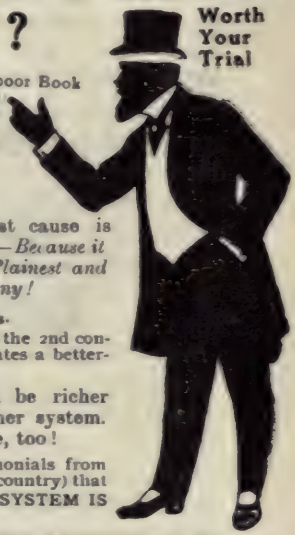

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denal ulcer and chronic appendicitis, but he does not limit himself to typical duodenal ulcer. However, by a detailed analysis of the various symptoms of ulcers and appendicitis the clinical differentiation between the two processes can usually be made.

In chronic appendicitis, as in duodenal ulcer, the pain may be felt in recurring paroxysms. In certain forms the predominating digestive disturbances consist of epigastric pain, occasionally with periodical exacerbations, acid eructations, and an increase in the acidity of the gastric juice, so that the diagnosis may well be difficult. In order to arrive at a correct conclusion an entire group of symptoms should be present, although any one of them may be wanting, but each one which exists gives more value to the general conformity of the diagnosis. In point of fact, there is not a single diagnostic sign which may not be misleading.

In the first place, the provoked right-sided pain in appendicitis should be deep-seated, and constant over McBurney's, Morris' or Lanz's points, persisting in the form of lameness after cessation of pressure, and set up by deep pressure made on the left side of the abdomen, which causes dilatation of the cæcum by forcing the intestinal gas into it. Spontaneous pain has no absolute diagnostic value, while irradiations of both spontaneous and provoked pain are occasionally so acute that they may lead to an erroneous conclusion as to their starting point. Thus the irradiated pain in the epigastrium, very frequent in the gastric forms of chronic appendicitis, may lead to the suspicion of a gastric or duodenal ulcer, but in this case, if a finger presses upon McBurney's point while with the other hand the examiner searches for sensitiveness in other areas, the principal site of provoked pain can usually be detected.

The difficulty of localizing pain in the right umbilicoiliac area is well shown in a paper by Loeper and Esmonnet (*Bulletin médical*, May 28, 1910), who divided the abdomen into a series of areas of sensitiveness corresponding to various sympathetic chains. The principal points are the epigastric; the upper mesenteric, which corresponds to Morris' point, and represents the small intestine and the right half of the colon; the lower mesenteric point, three centimeters from the midline and three centimeters below the umbilicus; the solar plexus area, corresponding to the umbilicus and periumbilical area; and lastly, the aortic point, situated between the mesenteric

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points and promontory. In relation to the deep-seated viscera, these points reveal pain the causes of which are most varied, while their multiplicity on the right side of the abdomen indicates the delicacy of a diagnosis based on pain in this region.

On the other hand, we have the duodenal and appendicular zones of Head, but unfortunately all these cutaneous areas, from the diagnostic viewpoint of duodenal ulcer and chronic appendicitis, offer no serious data on which to rely. While these areas of cutaneous hyperesthesia may not exist in either process under consideration they may be present in certain individuals possessing a hypersensitive nervous system but with absolutely normal abdominal viscera. The impossibility of utilizing Head's points is all the more unfortunate because the diagnostic difficulty is increased in cases of gastroduodenal ptosis. In these cases a pyloric or duodenal pain may easily be attributed to the appendix.

It is evident that an intestinal hæmorrhage will fix the diagnosis in favor of duodenal ulcer, but this symptom is frequently wanting. Therefore, occult hæmorrhage must be sought for by either Weber's or Meyer's technique, and although their positive reaction confirms the presence of an ulcer, a negative result does not invalidate it. A duodenal ulcer does not bleed constantly, and for this reason the stools should be examined for blood on several successive days.

Finally, radiography, after a bismuth meal, will complete the diagnosis, particularly when, as is usually the case, adhesions exist between the first portion of the duodenum and the liver.—*Medical Record.*

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### On Regeneration of Joints

E. Payr has collected various data relating to regeneration of traumatic lesions and dislocations of joints. The genesis of fissure of a joint would seem to be more particularly related to the movement of the various parts composing the joint, the shape and extent of the fissure being decided by the muscular movements and the point of insertion of the muscles. From the viewpoint of development, Payr recalls that the articular capsule of many vertebrates possesses a layer of cartilage over its entire extent, the synovial membrane thus representing a modified type of cartilage. The synovial fluid must not be regarded as an inert liquid having a passive rôle, but rather as a product

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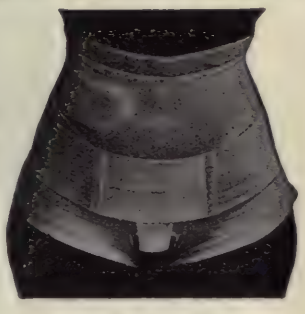

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of a processus of wear of both cartilage and synovial membrane, and it plays an active part in the nutrition of the joint, and, perhaps, even in histogenesis. From the viewpoint of regeneration it is the most inert tissue of the body, cicatrization of traumatic injuries to it being always insufficient when not aided by the intervention of the perichondrial and subchondrial connective tissue structures. Other than for the cartilage, joints are among the structures giving rise to the most perfect regeneration, and the writer supposes this to be due to the relative simplicity in function and the slightly advanced differentiation of the parts making up a joint. Repair is more complete in surfaces undergoing reciprocal friction than in the complementary surfaces of the joint, from which it results that glenoid joints undergo better repair than hinge joints. The joint capsule possesses an astonishing regenerative faculty. This fact is illustrated by its rapid repair after extensive excision as is practised, for instance, in chronic arthritis with a fluid collection (lymphatic drainage of the joint). As to the joint ligaments, their possibility of regeneration has been little studied, but as a feeling of insecurity exists in this respect, it has given rise to aponeurotic plastic operations, sutures, etc.—*Medical Record.*

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**Liver Abscess Simulating Pleural Effusion**

The lack of a single reliable pathognomonic physical sign in liver abscess renders its diagnosis difficult and dependent on a careful survey of all the available evidence. Even so it may escape detection, an as in the following case, all the signs, including Grocco's paravertebral triangle, may indicate a pleural effusion.

A soldier, aged 23, who had suffered from typhoid fever half a year earlier, was admitted to hospital with the diagnosis of apical catarrh of the lungs and pleurisy on the right side. He had coughed for months and had complained of pain in the right side of the body and in the feet. The muscles were flabby and atrophied, the skin was pale and pitted on pressure over the legs, back of the left hand, abdomen and lumbar region. The lips and nails were cyanosed, and mucous membranes pale. Respiration was 16 and costo-abdominal, and the movements of the right chest lagged behind. The per-

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cussion note was impaired over the apex of the right lung, and dull from the middle of the interscapular space, downwards. This dullness extended in the mid-axillary line up to the fifth rib. Behind, this dullness extended to the left of the middle line, forming a triangular area adjoining the vertebral column. The intensity of this dullness increased as it was traced downwards, and its upper limits were not affected by respiration. Bronchophony and vocal fremitus were diminished over the dull area. There were no tubercle bacilli in the scanty sputum. The abdomen was tense and somewhat distended, and its walls were œdematous. The right abdomen was slightly tender and resistant. The urine contained 1.2 per cent. albumen, leucocytes, red cells, and a few granular casts. The temperature was 99 deg.

The œdema and the condition of the urine suggested amyloid disease of the kidneys. All the physical signs pointed to an accumulation of fluid above the diaphragm. The location of this fluid by the X-rays was not attempted as the patient was very weak. Exploratory puncture of the right chest was negative. It was repeated next day elsewhere in the right chest with a bigger needle, on the assumption that the fluid was too viscid and thick on the previous day to pass. But again the result was negative, only a few drops of blood being aspirated. The patient died on the third day.

At the necropsy an abscess, of the size of a man's head, containing thick, yellow, friable, doughy pus, was found in the right lobe of the liver. The peritoneum was intact. Both liver and kidney showed amyloid disease, but the lungs were normal, except for a few caseous tubercles on the pleural surfaces. The abscess had probably followed infection from the intestines, although infection through a wound in the skin, or retrogade embolism, could not be absolutely excluded.

Signs of liver abscess had not been lacking. There was pain over the region of the liver which was enlarged and tender. The pain, however, was interpreted as pleural, and owing to the rigidity and œdema of the abdominal wall, local protrusion or fluctuation of the liver was undetected. The lack of jaundice and of a high intermittent temperature were also misleading.—*The Medical Review.*

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Aposthesine is a local anæsthetic resembling stovaine and novocaine, and said to be non-toxic. It is evidently the product described in *The Prescriber,* 1917, p. 129, as *Apothesine,* which is used as a 0.5 per cent. solution in 0.4 per cent. sodium chloride with adrenalin.

Arsaminol is the name given to a Japanese make of salvarsan or arsenobenzol.

Biosulfol is a French preparation of colloidal sulphur, recommended in rheumatism and skin diseases. The dose is one teaspoonful.

Chromo-Santonin or *Golden Santonin* is a modification of ordinary santonin formed by exposure to sunlight. C. Begg has given it in sprue, the dose being 3 grains morning and evening in oil for three days. C. F. Still, in his Lumleian Lectures on cœliac disease (*Lancet,* 1918, 2, 229; Aug. 24), has given it with some success in this condition. The dose given was 1 to 2 grains in capsule.

Pallamine is a colloidal preparation of palladium, recommended by J. E. R. McDonagh (*B.M.J.,* 1918, 2, 31; July 13) in the chemotherapeutic treatment of gonorrhœa.

Quinacol is a chemical combination of quinine and guaiacol, containing 50 per cent. of each. The dose is 2 to 4 minims, in capsule (Allen & Hanburys, Ltd.).

Thiarsol is a French proprietary solution of coloidal arsenic trisulphide, strength 1:2000.—*The Prescriber.*

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